New Hampshire Building Capacity for Transformation 1115 Medicaid Waiver

IDN PROCESS MEASURES SEMI-ANNUAL PROGRESS REPORT

For

Year 5 (CY2020)

July 1 – December 31, 2020

Redacted

Region 7 IDN

Introduction

The Centers for Medicare and Medicaid Services (CMS) approved New Hampshire's application for a five-year Medicaid demonstration project to improve access to and the quality of behavioral health services by establishing regionally based Integrated Delivery Networks (IDN) and developing a sustainable integrated behavioral and physical health care delivery system. To achieve the goals of the demonstration waiver, the IDNs are charged with participating in statewide planning efforts and selecting and implementing community-driven projects. These projects are built around three enabling pathways: mental health and substance use disorder treatment capacity building, integration of physical and behavioral care, and improving transitions of care across settings.

Per the Standard Terms and Conditions and contractual requirements Integrated Delivery Networks who have met 100% of the required deliverables will be required to submit ongoing Semi-Annual Progress Reports. It is the expectation that all partners will continue to make progress along the SAMHSA Integrated Care Practice Designation Continuum.

Submission of the semi-annual progress report shall be a single pdf document which includes all attachments. In addition, due to printing and size constraints, your attachments should also be uploaded separately in the original file version as well (ms project, ms excel, etc.). The January- June 2020 semi-annual report is due July 31, 2020 and the July-December 2020 semi-annual report is due January 29, 2021. Attachments should use the naming convention identified in the weekly update dated week ending July 7, 2017. The naming convention shall correlate with the project deliverable for which it is being submitted.

To be considered timely, supporting documentation must be submitted electronically to the State by the dates indicated above into each IDN's semiannual reporting folder. For questions, contact:

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Project Plan Implementation (PPI)

Narrative

Provide a detailed narrative to reflect progress made during this reporting period as it relates to the Administration, Network, and Governance.

Reporting in A Pandemic

Many partners in Region 7 have dedicated considerable time and effort during the reporting period working to ensure that their most vulnerable patients and clients remained connected to services, whether virtually or in person. There is a keen sense in the region that the last five years' work towards building inter-agency connections has helped make this care of vulnerable populations easier. With that said, many partners have also noted that there are some processes which were either temporarily abandoned or significantly altered in order to accommodate staff shortages and the multitude of process changes that were required in order to ensure that their staff members and community members were safe during the pandemic. As a result, not all partners have been able to dedicate time to producing quantitative data that informs this report, or to sharing detailed narrative reports of their work.

Whenever possible, this report has been informed by both active discussions with partner staff, and passive monitoring of partner activities through their most frequently used media outlets. Reporting gaps do remain, however, and as a result some of the performance targets may appear to reflect losses or regressions as a result of incomplete data sets. Additionally, some partners may not be represented in the "Partner Specific Reports" sections of each project, or might have limited mention, despite being listed as a Key Organization for the project.

Governance

The Steering Committee continued to meet regularly, and the sub-committee workgroups remained available to provide each other support throughout the reporting period. North Country Health Consortium (NCHC), as the Region 7 IDN Lead Agency, continued providing backbone support by staffing the IDN7 Team, which dedicated time during the reporting period to providing additional collaborative opportunities to partners as they continued to work through the challenges of the COVID-19 pandemic. This included the continuation of weekly "COVID Touch Base" town hall style calls for partners to provide updates and ask for support when needed. The partners who attended these calls expressed that the meetings were valuable to the region, keeping participants well informed of similar and differing struggles each agency was facing.

The IDN7 Team also shared state-wide resources with Region 7 partners aimed at addressing Social Determinants of Health (SDoH) such as housing and food insecurities, access to COVID-19 testing and personal protective equipment (PPE). The IDN7 Team also leveraged NCHC's usual communication channels, including websites, print media and social media, to amplify messaging from regional partners regarding safe practices and quarantine/isolation guidance from the Division of Public Health Services.

Steering Committee

The Steering Committee has continued to meet regularly with staff from the Administrative Lead Agency to make informed decisions about the work and legacy of Region 7 IDN. The Committee has fulfilled their primary role determined at the start of the project by taking responsibility for the strategic vision, fund allocation, and the achievement of project metrics. The majority of the reporting period was spent developing an appropriate allocation plan for the remaining incentive payments available to the region.

On July 23rd, development began with a Governance Meeting to gather region-wide ideas from all workgroup members regarding the proposed allocation plan. A limited number of workgroup members attended the session, at which they were provided a summary of funds available, reminders regarding the allowable uses of funds, and several proposed suggestions for the use of these funds in the region – most with an eye toward sustaining the legacy of the Region 7 IDN beyond the end of the demonstration. A survey to the full governance body followed, in which members were asked to rank order the ideas discussed and assign dollar amounts to each idea. The Steering Committee met on August 25 to discuss the results of the incentive payment allocation survey and reiterate the importance of approved expenditures aligning with the region's project and implementation plans, as well as DSRIP goals. Due to the limited response rate on the survey, the group was challenged to define an efficient and effective method to distribute remaining funds with consensus.

In response to this challenge, the Steering Committee reviewed the project plan more deeply and contemplated a tiered approach to distribute the remaining incentive payments to partners throughout the region. The group received two proposals for extensions of work happening in the region, allowing for targeted work by Community Health Workers (CHWs) and the recovery community to be funded through 2022. Additionally, the Steering Committee agreed to continue funding the region's connectivity to the Collective Medical Network, and limited support from the IDN7 Team through 2022. They also directed the IDN7 Team to discuss the proposed funding ideas with the DSRIP contacts at New Hampshire Department of Health & Human Services in order to probe their acceptability before decisions were made regarding final use of available funds.

As a result of this extensive work through the summer and early fall, a final plan was created and discussed by the Steering Committee during the October meeting. A unanimous vote from the Steering Committee approved the proposal allocation plan to be sent to NH DHHS for review. The final proposed plan was approved by DSRIP contacts at NH DHHS with guidance to determine accountability strategies for partners receiving funds. The funding allocation plan was then proposed to Region 7 partners at the All-Partner Quarterly meeting on November 19 and was approved by those in attendance.

During the month of December, the Memoranda of Understanding (MOUs) for the spending plan were developed with a goal of offering funding to partners in early January. Additionally, the Steering Committee and the IDN7 team continued to have further discussion regarding sustainability of the progress made by the region during the demonstration beyond December 2020, and accountability strategies for funds being distributed. The Committee also agreed to move to an as-needed cadence for the other workgroups, recognizing that in most cases the original charge for the groups had been largely met and that they can be reconvened easily when the need arises.

Allocation of Funds

The proposed plan, approved by NH DHHS, is shown below. The Steering Committee was given multiple points to consider during this reporting period and sought guidance from the entire governance structure and regional partners during the November Quarterly Meeting. The members agreed that the

governance infrastructure will need to remain available to the region beyond the December 2020 period to assist with decisions regarding any residual funds remaining at the end of the contract period. The group also had discussions regarding the importance of a defined mechanism for distribution and auditable reporting for the life of the fund expenditures be in place. The Steering Committee agreed to roll out MOUs to distribute the remaining funds as outlined below. Members agreed a tiered approach to all partners listed in the Workforce & Integration section would be appropriate for the distribution of any residual incentive funds that become available after December 2020. The IDN Steering Committee is prepared to continue monthly meetings until June 2021 to help guide the region into post-DSRIP activities using the remaining incentive funds available.

Region 7 DY5 Spending Plan Component	Amount	Cumulative spend down	Amount remaining to spend ($2.8M to	Rationale
Collective Medical Network's platforms for three more years (Jan 2021 - Dec 2023): PreManage ED (static amount per year = $32,786 x 3 year commitment for Region 7 IDN) and PreManage Primary (variable cost calculated by assuming current rate of $0.12 PMPM and 19,138 lives atributed to Region 7 IDN as of September 2020)	$ 181,034.16	$ 181,034.16	$ 2,618,965.84	Strong support among partner agencies to ensure that they can remain connected to the CM network long-term, and that partners not yet connected due to local bandwidth constraints have the opportunity to connect to the network as other projects come to an end.
Lead agency management of residual IDN7 activities from July 2021 through December 2022 - KvB 8 hrs/mo, AM 4 hrs/mo, CR 2 hrs/mo; continue to revisit on a quartelry basis	$ 15,000.00	$ 196,034.16	$ 2,603,965.84	Provides ongoing financial support for lead agency to continue responding to DHHS requests and manage extended-use and residual funds through December 2022; propose a quarterly review of ongoing need.
Expansion of Ways2Wellness Connect (W2WC) Community Health Worker proposal (assumes 3 CHWs from Jan 2021 - Dec 2022; see attached)	$ 550,000.00	$ 746,034.16	$ 2,053,965.84	Continuation and further expansion of proposal approved by Steering Committee in June 2020, allowing for three CHWs to continue providing direct services, technical assistance and workforce development to IDN partners and their patients through December 2022
Carroll County Expansion Proposal (see attached)	$ 285,370.00	$ 1,031,404.16	$ 1,768,595.84	Supports collaborative effort of partners in Carroll County to continue the development and stability of expanded Substance Use Disorder treatment and recovery supports in Carroll County. Carroll COunty Coalition for Public Health (C3PH) has been identified as the separate fiduciary agent to manage funds through December 2022.
Integration and Workforce Development Funds - used by partners to enhance integration and support workforce development; funds are distributed to partners employing positions listed in the A1 table in a tiered fashion (IDN7 partners not included on the A1 table: AHEAD, NAMI, C3PH, Grafton County Department of Corrections, Hope for NH Recovery, ServiceLink, North Country Healthcare)	$ 1,460,000.00	$ 2,491,404.16	$ 308,595.84	Funds are intended to distribute remaining incentive payments earned across partners who have been project-engaged. Partners will be expected to show through annual reporting that the funds have been used for workforce recruitment, retention and development, ongoing integration of physical and behavioral health services, improved transitions in care and continued strengthening of closed loop referral processes between Medicaid providers and the community based organizations to aid in the resolution of identified needs related to the social determinants of care. Funding is provided to IDN7 partners listed in the A1 Key Organizations table, with amounts tiered based on the partner involvement in DSRIP projects and functions across the region.
13 B1 Medical, MH and SUD providers - $75,000 each	$ 975,000.00			Share of residual funds for this tier 50%
5 CTI & RCO providers - $50,000 each	$ 250,000.00			Share of residual funds for this tier 25%
8 Home Health, Social Service & Case Management agencies - $20,000 each	$ 160,000.00			Share of residual funds for this tier 15%
5 remaining A1 partners - $15,000 each	$ 75,000.00			Share of residual funds for this tier 10%

Clinical Workgroup

The Clinical Workgroup has continued to be available to advise the IDN Steering committee regarding clinical pathway standards, and how to monitor fidelity, performance, and patient outcomes of the Region 7 IDN. The workgroup was invited to the Strategic Funding Meeting in July to participate in the discussion regarding allocation of remaining incentive funds.

In light of the continued COVID-19 related activities underway, and the fact that the protocols, workflows, and standards of care that the workgroup was originally tasked to address have been completed, limited agenda items for the Clinical Workgroup remained. On a month-by-month basis, the workgroup opted to cancel meetings during the reporting period.

The workgroup remained committed to supporting IDN7 projects throughout the reporting period despite the cancelation of multiple meetings. The Clinical workgroup mailing list remained active for the purposes of sharing information and soliciting feedback.

Community Engagement Workgroup

The Community Engagement Workgroup has continued to advise the IDN Steering committee on ways to engage the entire Region 7 IDN community to gather input and feedback on improving patient outcomes in the region. The workgroup was invited to the Strategic Funding Meeting in July to participate in the discussion regarding allocation of remaining incentive funds.

Limited agenda items for the workgroup resulted in the cancelation of multiple meetings during this reporting period. Despite this disruption to the usual meeting cadence, members of the Community Engagement Workgroup have been consistent participants in the Region 7 IDN COVID Touch Base calls occurring on a weekly basis, where extensive discussions regarding the connectivity of the Network and communication pathways to the public are discussed.

Data/HIT Workgroup

The Data Workgroup has continued to advise the IDN Steering Committee regarding data sharing processes, use of existing technology, and identifying what is needed to implement standardized reporting and monitoring for the Region 7 IDN.

As with other workgroups, the COVID-19 pandemic continued to consume partner focus and depleted staff capacity to engage in workgroup meetings, resulting in multiple cancellations of these meetings during the reporting period. The IDN Data Lead continued to interface with partners on an individual level, helping them to navigate the data reporting demands created by the disengagement of MAeHC and aiding with other IDN-related technology initiatives while the region awaited further guidance from the state.

Finance Workgroup

The Finance Workgroup has continued to be in place to advise the IDN Steering Committee regarding decisions about the distribution of funds earned by the IDN over the course of the demonstration. The workgroup did not formally meet but remained available to the region on an as needed basis during this reporting period. In mid-June, the workgroup was invited to the Strategic Funding Meeting in July to participate in the discussion regarding allocation of remaining incentive funds. The group will continue to review proposals and budgets, as necessary.

All governance workgroup members were also invited to the Region 7 IDN Quarterly Meeting held on November 19, 2020 to celebrate regional success, IDN updates, partner progress and the future of the IDN beyond the DSRIP. About 30 staff members from partner organizations joined the virtual meeting to view the wrap up presentation developed by the IDN7 team.

Trainings

Region 7 partners continued to leverage multiple training opportunities that were made available to the region virtually during the reporting period. The Region 7 IDN team continued to share training opportunities regularly through the region's Basecamp communication platform and the Region 7 email list.

During this reporting period, the North Country Health Consortium's WARM team finalized the development of several virtual training opportunities including:

- Recovery Coach Academy training series: August 10-28, 2020
- Naloxone Train the Trainer: August 6, 2020

- HIV: Let's Face It. Town Hall Series: September 29th, October 20th, November 17th, & December 1st
- Suicide Prevention: December 7-11, 2020

The North Country Health Consortium's Ways2Wellness CONNECT team finalized the development of the virtual Community Health Worker training during this reporting period. The training was offered to the region beginning September 24, 2020 and graduated 9 individuals on November 12th. The CHW series also included a hybrid Motivational Interviewing training in October.

IDN7 Partner Cottage Hospital/Rowe Health Center applied for Training & Technology funds to host a Trauma Informed Training for Medical Staff/Providers. The proposal was approved by the IDN7 team, but the partner was unable to hold the in-person session due to complications related to the COVID-19 pandemic. They have a plan in place to hold the training in early 2021 through a virtual session instead.

Region 7 IDN team members have also been collaborating with the NCHC Workforce team to coordinate a 2021 training series for the region. NCHC's Northern NH Area Health Education Center has stepped into a contract with New Hampshire Alcohol & Drug Abuse Counselors Association to develop six trainings a year for two years to be delivered to the North Country. It is anticipated that many of these trainings will be virtual and available to Region 7 IDN partners.

Addressing gaps in care

Region 7 IDN partners have continued to address gaps in behavioral health care throughout this reporting period. The COVID-19 pandemic has had different impacts on providers and patients throughout the region. Despite the phased approach back to in-person appointments for some partners, many have continued most care through the use of telemedicine technology. Some providers continue to see a decrease in rates for no-shows and cancellations because patients are able to stay home for a virtual visit, which eliminates the barriers of severe weather, lack of transportation and the need for childcare. Conversely, some patients continue to experience exceptional difficulty connecting to virtual visits due to lack of access to technology and reliable internet connections.

North Country Health Consortium's staff on the Ways 2 Wellness CONNECT (W2WC) program used this reporting period to roll out a pilot expansion project that broadened their scope to working with adults 18 and older with poorly managed chronic disease. This project, scheduled to last from July 1, 2020 through June 30, 2021, also expanded the geography of the Community Health Worker (CHWs) service area to provide services in Carroll County for the first time. The program originally set goals to contract with eight hospitals and provide direct services to up to 50 new clients. The project includes a menu of direct service, technical assistance and workforce development activities with this expanded scope and the new reach into Carroll County. The W2WC team is hopeful that a secondary effect of this work is the development of further use cases to support the credentialing of CHWs in the state and development of reimbursement models that will pay for this non-clinical enhance care coordination mode. This is already proving to have a direct impact on addressing gaps in care that still exist throughout the region. As of November 2020, all CHWs are at full capacity treating several clients each and the goals for the year had been reached. This initial success was a primary driver in the Steering Committee's decision to support further expansion of the program by an additional CHW and funding to continue the project through December 31, 2022 as part of the Region 7 IDN Transition Plan.

Region 7 partners continue collaborating on creative solutions to lessen the burden for clients and leveraging the network to ensure that patients are appropriately connected to resources. North

Country Health Consortium's AskPETRA team has been working diligently during this reporting period to increase access to resources and facilitate continued collaboration across the region. The Region 7 IDN team has frequently updated partners on funding opportunities that could reduce the burden the pandemic continues to create throughout the region using the bi-weekly COVID Touch-Base calls and the Basecamp communication platform.

Opioid Crisis Response

Region 7 IDN partners have continued to support the recovery community during this reporting period. The Peer Recovery Coach Network continues to be developed with access to essential trainings that advance the expansion of the Certified Recovery Support Worker workforce across the region. During the reporting period, NCHC's Wellness and Recovery Model (WARM) staff finalized the conversion of the Recovery Coach Academy training series to a virtual setting, successfully developing a virtual program approved by the Connecticut Community for Addiction Recovery (CCAR). The new online interactive series was offered for the first time in August 2020, attracting attendees from across the state. The training included a combination of synchronous and asynchronous learning through Zoom sessions and self-paced modules on NCHC's Moodle platform.

The WARM team also reports that their staff dedicated time during the reporting period to engage police departments around the region on the expansion of the Recovery Oriented Policing Model adopted by the Littleton Police Department. They also continued outreach to local businesses with the intent of further expanding the Recovery Friendly Workplaces initiative.

At the time of this report, the IDN7 Team was unable to obtain additional information regarding the efforts of Weeks Medical Center's North Country Recovery Center (NCRC), due in large part to the efforts of the Weeks team in implementing a new Electronic Medical Record system and responding to the COVID crisis in their role as a state sanctioned COVID testing site.

Region 7 IDN Recovery Community Organizations (RCOs) continue to address the crisis collaboratively with social service agencies and clinical partners to ensure all needs related to social determinants of health are met for their clients. The pandemic continues to create a unique burden on the recovery community, which leans heavily on support group models to help their clients remain in recovery. The continuous inability to gather in the commonly small center spaces and forced isolation have made recovery maintenance challenging. The RCOs continue to provide as much support virtually and in-person to their clients as possible while adhering to social distancing guidelines but expressed concern that the colder months will pose yet another barrier as weather eliminates the opportunity to leverage outdoor meeting spaces. Clients also continue to have difficulty accessing technology to participate in virtual meetings.

The 24/7 Emergency Recovery support services program developed by White Horse Recovery and Mount Washington Valley Supports Recovery have worked diligently this reporting period to strengthen their relationships with Huggins Hospital to prepare for an expansion of their pilot program into the Huggins ED. The pilot program has continued to successfully service individuals presenting at Memorial Hospital ED with SUD related issues.

During this reporting period, the Steering Committee approved a collaborative proposal from Carroll County partners to continue addressing the Opioid Pandemic throughout Carroll County. Representatives from Carroll County Coalition for Public Health (C3PH), White Horse Recovery Behavioral Health Services, Mount Washington Valley Supports Recovery, Memorial Hospital, Huggins

Hospital and the NCHC WARM and AskPETRA teams met to identify opportunities to expand the initiatives that Carroll County partners currently have in place or are working to implement, with a focus on integrated services and workforce development. This proposal places emphasis on those services and supports that can be shared and interwoven into the Carroll County partner's initiatives to increase their scope and ensure sustainability. C3PH worked with its parent organization, Granite United Way, to offer its services to act as a fiscal agent and subcontract resources so that Carroll County IDN7 partners can carry out activities over two years that will increase awareness of, increase access to and expand capacity for regional substance use services.

Budget

Please provide a budget of actual expenditures and projected costs to complement narrative.

Project	CY 2016 Actuals	CY 2017 Actuals	CY 2018 Actuals	CY 2019 Actuals	Jan-June 2020 Actuals	July-Dec 2020 Actuals	CY 2021 Projected
PPI	$66,115	$1,148,128	$2,034,438	$1,584,807	$354,849	$412,051	$3,174,132
A1	$15,956	$277,087	$424,149	$339,150	$74,225	$89,254	$318,764
A2	$8,822	$153,205	$511,463	$367,294	$88,389	$91,691	$176,152
B1	$25,576	$444,143	$677,601	$540,758	$118,348	$142,311	$508,254
C	$5,254	$91,231	$140,409	$112,535	$24,629	$29,616	$105,771
D	$5,254	$91,231	$140,409	$112,535	$24,629	$29,616	$105,771
E	$5,254	$91,231	$140,409	$112,535	$24,629	$29,563	$105,767
(Rounding may slightly impact totals by no more than $3)							

At the beginning of the demonstration, Region 7 opted to take the approach of budgeting based on how incentive payments are earned. This approach has been used for staffing as well as partner requests for funds and was adopted because partner proposals and staff time often touch multiple DSRIP projects concurrently. Expenses have therefore been allocated as a flat percentage across project areas, with the region setting out initially to roughly budget the funding across projects in parallel to the proportions in which the incentive payments were earned.

As funding uncertainties mounted in 2018 and 2019, the region maintained the original allocation rather than making the shift in the weighting from the state-wide projects to the core competency project. This has resulted in allocations of approximately 42% of funding to state projects, 36% to the core competency project and 22% to community projects for the life of the DSRIP. Proposed expenses for the remainder of the demonstration include anticipated costs for infrastructure staffing, subscription to the Collective Medical Network and distribution of remaining earned incentive payments to partner organizations in support of their ongoing work to meet the goals of the DSRIP. Variances experienced to date include:

- Reductions in incentive payments available following decreased county contributions for years 3 and 4.
- Failure of the region to meet 100% of incentive payment targets for both process and performance measures.
- The restructuring of infrastructure staffing in line with decreased funding earned by the region, the rationale being that if there was less money available for partner organizations, the infrastructure team should be similarly reduced.

Project A1: Behavioral Health Workforce Capacity Development

Narrative

Each IDN was required to complete an IDN level Workforce Capacity Development Implementation Plan, inclusive of the workforce needed to complete projects A1, A2, B1 and the IDN selected Projects C, D, and E.

Provide a detailed narrative to reflect progress made/activity toward recruitment, retention, hiring and training during this reporting period.

Include in your narrative detail of Key Organizations and Providers that have been off boarded as well as new partners/affiliated organizations and the effective date of the change.

Network Membership

During the reporting period of July 1 through December 31, 2020, one partner, NCHC Clinical Services/Friendship House, left the network, bringing the total number of partners in the Region 7 IDN to thirty-eight (38). The information below speaks to the progress that Region 7 IDN has made on the A1 project "IDN-Level Workforce Capacity Development" during this reporting period.

Statewide Workforce Capacity Development Collaboration

Workforce Taskforce

During the reporting period, it has been evident that the regions have done substantial work building and implementing training plans, educational opportunities, and workforce recruitment and retention strategies throughout the demonstration. The Statewide Training & Education Workgroup was a key component of the state's success and was dissolved during last reporting period because the goals it had been charged to meet were reached. The Statewide Workforce Taskforce remains available for future decisions and guidance, as necessary.

Retention of Licensed Mental Health Professionals

Northern Human Services (NHS), the region's only Community Mental Health Center (CMHC) has previously reported that CMHCs are valued as organizations in which newly graduated professionals can gain practical experience and be supervised and mentored by more seasoned professionals, but current low reimbursement rates for CMHCs make it difficult for these agencies to offer competitive wages. As a result, it is common to experience high turnover as less seasoned professionals seek out higher salaries when their supervision periods are over, and the salaries are not competitive enough to attract experienced professionals. Northern Human Services continues to advocate for CMHCs to receive Federally Qualified status, which will allow them to receive higher reimbursement rates and in turn offer more competitive salaries to staff as a retention strategy. As the region continues to discuss sustainability of IDN projects in the last year, recruitment and retention remains a high priority for all partners.

The retention of Licensed Mental Health professionals was, interestingly, less of a challenge during this reporting period than it has been in prior periods. NHS reports that their agency is fully staffed for the first time in memorable history, with sufficient clinician numbers to provide services to all existing and Emergency Services clients in the region without extensive wait lists for services. Partners across the region have continued to find ways to hire and retain behavioral health providers, with the most success

being realized through "grow our own" models that provide tuition assistance to existing staff seeking licensure and certification, rather than recruiting candidates from outside the region. This has been particularly important during the COVID-19 pandemic as available housing stock has been consumed by individuals and families from more urban areas have fled to rural pockets of the state in an effort to avoid high case counts. Partners who have attempted to recruit staff from outside the area report that they are more likely to lose candidates due to their inability to secure housing during the pandemic as a result.

Mental Health First Aid

As noted in prior reporting periods, Region 7 IDN partners continue to struggle with training non-direct staff in Mental Health First Aid due the 8-hour time commitment asked of the curriculum. As an alternative, the Region 7 IDN team developed and recorded an on-demand Mental Health Awareness module. This module is designed to help non-direct staff improve their cultural sensitivity towards individuals with mental health needs and improve the likelihood that they will use best practices when responding to individuals they encounter who may be struggling with behavioral health needs. The video remains posted on the NCHC YouTube Channel in March 2020 and the region's Basecamp site. Templates for tracking employee participation in this training are also available for partners to use, as necessary.

As of December 2020, the webinar had been viewed 89 times on the NCHC YouTube Channel. Please note that this is the number of times the video has been viewed, not the number of people who have viewed the video. Partner organizations had the option to arrange for staff to view the training in group settings. Partners were provided with templates for tracking the number of staff members who completed the training, and to date no attestation forms have been submitted. The IDN7 team will continue to remind partner organizations that this resource exists as an easy and brief way to raise awareness about behavioral health needs among the populations they serve.

Throughout the demonstration, NCHC has maintained two staff members trained as Mental Health First Aid instructors. This evidence-based training, sponsored by the National Council for Behavioral Health, is designed to prepare community members to identify signs and symptoms and to respond compassionately with resources to someone experiencing a mental health concern or crisis. During the pandemic, NCHC staff trainers completed a recently updated modified virtual training of trainers in order to be able to deliver the curriculum and materials through virtual platforms. **The NCHC trainers are preparing to provide several virtual trainings to IDN partners and organizations in 2021.**

NHADACA subcontract

In September 2020, NCHC, as the home of the Northern NH Area Health Education Center (NNH AHEC), subcontracted with the New Hampshire Alcohol and Drug Counselors Association to offer six trainings in 2020 and six trainings in 2021 on topics related to substance use disorders to an interprofessional audience in our region. Our first training on January 28, 2021 is on the topic of substance use disorder concerns among our older NH population. A second session on risks of depression and suicide among NH's rural older population is scheduled for February 11, 2021. Additional topics on impaired driving rules and regulations and trauma informed care are being planned.

Investment in Education for Integrated Healthcare Professions

Health Careers Catalog

Region 7 IDN team members and NNH AHEC staff continue to encourage schools to utilize the 5th Edition AHEC Health Career Catalog to provide students a clearer picture of the pathways available for individuals to pursue a health career. The catalog continues to be a valuable recruitment tool for the region and is often used to promote healthcare career ladders for high school students, college students, and those looking to change professions.

Live, Learn, Play in Northern NH

There were three behavioral health students who completed their Live, Learn, Play in Northern NH (LLP) rotation during this reporting period under the IDN funding source.

- A master's level social work student at the University of New Hampshire interned at White Mountain Mental Health/Northern Human Services. During the LLP period, this student completed a project to provide behavioral health clinicians with resources they could suggest for their clients to help them connect with the outdoor environment to assist in recovery and overall wellness.
- A master's level Clinical Mental Health Counseling at Plymouth State University interned at White Mountain Mental Health/Northern Human Services. This student completed a community project on compassion fatigue.
- A bachelor's level counseling student at Grand Canyon University interned at White Horse Recovery & Behavioral Health Services. This student completed a project to provide case management supports to inmates after release from incarceration.

In addition, funding available through NCHC's AskPETRA program supported one additional student during the reporting period. This master's level social work student at the University of New Hampshire, completed a second LLP project and rotation, started his rotation in 2020 and planning to complete by May 1, 2021. He is interning at Indian Stream Health Center and is planning a project to provide clinical staff with tools for screening and diagnostic information to increase the efficiency of providing behavioral health services in a primary care setting.

Multiple partners, including Ammonoosuc Community Health Services, Huggins Hospital, Indian Stream Health Center, Memorial Hospital, Northern Human Services, White Mountain Community Health Center (WMCHC) and White Horse Recovery (WHR) continue to hold space for behavioral health students to complete rotations as needed. Despite this willingness to serve, complexities created by the COVID-19 pandemic have resulted in fewer student placements during the reporting period, either because the telemedicine models in use by partners did not have a means to include students in the process, or because academic institutions were not placing students at practices due the fear of unduly exposing students to COVID-19.

Ongoing Care Coordinator Skills Development

The Region 7 IDN Regional Care Coordinator Network (RCCN) continued to serve as a vehicle for the support and skills strengthening of the Care Coordinators and Care Advocates in the region. The RCCN has continued to provide care advocates across the region with a peer cohort that serves as an asset for collegial communication, support, and access to resources to further enhance care coordination within the region.

During this reporting period the RCCN convened virtually on August 12, September 19, October 14, and November 11, to continue discussions regarding current care coordination work throughout the region. The group also discussed successes, challenges, and resources available to address current needs.

Members of the RCCN stated that lack of bandwidth continued to impact collaboration, education, or professional development related to care coordination. The COVID-19 pandemic remains a strong consideration for all departments with staff members continuing to be retasked to COVID activities and healthcare organizations have experienced financial downturn. The reality of this added burden continues to shift the meetings away from professional development to focus on staying updated on what is happening with care coordination at partner organizations. This includes the coordination of reimbursed services like Medicare Annual Wellness Visits, Transitional Care Management, Chronic Care Management, and chronic disease education are several key activities for which there are sustainable reimbursement models that adequately offset labor expenses. These activities are prioritized over other activities that have less clear or dependable sustainability models. Most care coordinators are also nurses, and many reports that during the pandemic they have been called upon to staff COVID testing and visitor screening positions because they are not directly involved in patient appointments.

AskPETRA Advisory Group

The AskPETRA team worked with their Advisory Group during this reporting period to develop a Recovery Community Organization toolkit of trainings. While the first offering was not delivered until after December 31, the team undertook a significant amount of collaborative work to create this toolkit, which will be present on the AskPETRA website. They have also created two new trainings that will be offered on the NCHC learning platform. As the new year begins, the group will continue working collaboratively to create a 42 CFR Part 2 learning collaborative with education as well as skills practice. In this module, the first three sessions are designed to be heavily education focused, and last 3 sessions are review of education and case examples that each organization will submit for sharing. Region 7 IDN partner Family Resource Center has already decided to make this a mandatory training for their Strengths to Succeed staff (one of the region's Critical Time Intervention teams). Additionally, the group is working to build a training for professionals who work with clients that have co-occurring substance use and behavioral health disorders.

Community Health Workers

North Country Health Consortium's Ways2Wellness CONNECT (W2WC) staff deployed another session of their redesigned Community Health Worker (CHW) training with the new curriculum in a virtual setting during this reporting period. The series kicked off on September 24, 2020 and graduated 9 individuals on November 12th. The CHW series also included a hybrid Motivational Interviewing training in October.

On July 1, the W2WC team began implementation of the expanded Community Health Worker (CHW) services plan funded by Region 7 IDN. As mentioned, the W2WC program expanded their practice both to Carroll County (an additional service area) and to upstream patients who are younger and earlier in their chronic disease journey (a new demographic). This expansion has flourished during this reporting period, serving the 50 new clients they set as their 1-year goal. The W2WC program currently has newly signed Memoranda of Understanding (MOUs) and Business Associate Agreements (BAAs) with IDN7 partners Weeks Medical Center, Coös Country Family Health Services, Huggins Hospital, Cottage Hospital/Rowe Health Center, Indian Stream Health Center and Littleton Regional Healthcare. These relationships help the W2WC program reach the goals of the expansion project to work with eight IDN partners to deliver CHW training and direct client services.

The program staff have not received any requests for formal mentoring during this period, but the W2WC and WARM Teams did provide technical assistance to Carroll County partners including White Horse Recovery and Behavioral Health Services, Carroll County Coalition for Public Health, and Mount Washington Valley Supports Recovery as they drafted a proposal to expand supportive services to Carroll County residents with substance use disorder even further. Additionally, the first planned CHW training was held in September and the program was able to train individuals from all three counties in Region 7. This was a planned portion of the expansion funding that started on July 1, with two trainings scheduled – one in the Fall of 2020 and another is for Spring 2021. Due to the success of the initial one-year project, the Steering Committee received and approved a proposal to further expand the project by adding an additional CHW and extending the end date of the project from June 30, 2020 to December 31, 2022. Recruitment for another CHW began in December, and a hire is anticipated to occur in January.

Work also continues with the CHW Coalition on regional and state levels. The CHW teams from NCHC report that there is a tremendous amount of advocacy work going on within the coalition to inform leaders and decision makers regarding the value of CHWs. In October, the first Coalition annual meeting was held virtually, with about fifty stakeholders and CHWs statewide. Focus was on CHW certification in New Hampshire. Attendees were educated on the topic, and a vote resulted in the Coalition being charged to move forward with the development of a CHW certification pathway for the state. A coalition certification committee has developed a strategic plan to work through multi-level processes that need to be considered for certification and the coalition has also engaged with other states and content experts regarding options that NH can pursue. Currently, the team is holding informal content expert stakeholder meetings with education institutions around the state. Two lanes of certification development underway address both the education and decision making of the CHWs, and the parallel education and engagement of administrators and decision makers. The State of NH continues to be supportive of these efforts.

In addition to the work on a state certification process, the coalition actively shares and promotes professional development and job placement opportunities through their statewide Basecamp site and newsletters. NCHC provides administrative technical assistance through Senior Program Management, and individual CHWs serve as coalition leaders, with two NCHC staff members sitting on the NH Coalition Steering Committee and four NCHC staff members serving on the coalition certification committee, one seated as a co-chair. On the Steering Committee, one staff member is a co-chair, and another is a regional chair. One of the NCHC staff members also sits on the National CHW Association policy committee and brings national policy pieces to the state with the intent of promoting the value of CHWs and workforce development.

Peer Recovery Workforce

The peer recovery workforce and recovery community organizations continued to collaborate to face the many new challenges the region has been experiencing. North Country Health Consortium's Wellness and Recovery Model (WARM) team finalized the online format of their newly developed Recovery Coach Academy training series to an online format. The virtual series received approval from the Connecticut Community for Addiction Recovery (CCAR) during this reporting period and was offered to the region in August 2020.

During this reporting period, several other trainings and events were offered to continue strengthening the recovery workforce and improve community awareness:

- Recovery Coach Academy training series – August 10-28, 2020
- Naloxone Train the Trainer – August 6, 2020
- HIV: Let's Face It. Town Hall Series – September 29, October 20, November 17, & December 1
- Suicide Prevention – December 7-11, 2020

In addition, NCHC's Wellness and Recovery Model (WARM) program has been able to expand the reach of services for individuals through collaboration and connection with non-traditional referring agents such as drug treatment courts and police departments to improve access to social services and ease navigation for participants. The WARM team also helped Northumberland Police Department sign an MOU to adopt a Recovery-Oriented Policing Model (ROPM). At this time, they have entered the training phase and began planning to train all officers in the ROPM Bootcamp, in addition to training a staff member as a recovery coach and resource broker. They have also begun to plan out and develop their own individual model, with the support of the town. Northumberland is the second police department in the region to engage in this model.

NCHC continued work on the new AskPETRA program that was initially launched in April 2020., funded through a grant from the Health Resources and Services Administration. This initiative has begun to strengthen and expand Substance Use Disorder/Opioid Use Disorder (SUD/OUD) prevention, education, treatment, and recovery programming in the North Country.

The AskPETRA and WARM program also continued efforts during this reporting period to strengthen relationships between the region's recovery community organizations and clinical partners as they pivoted to focus their efforts on delivering services in the context of statewide COVID-19 response. The COVID-centric resource AskPETRA database that was developed in the previous reporting period, and expansion of the existing database that was specifically related to SUD resources, has proven to be a major asset to Region 7 partners during the ongoing pandemic.

The 24/7 Emergency Room response program run by Mount Washington Valley Supports Recovery (MWVSR) and White Horse Recovery and Behavioral Health Services (WHR) has seen an upswing in encounters and positive outcomes throughout September. The team has had success in moving people from the emergency department to detox, treatment, and/or community providers. The coaches from MWVSR and WHR have made huge inroads to follow protocols developed and instituted, resulting in emergency department staff becoming more comfortable to call for services. During the reporting period, the organizations met to review and update the program with the Memorial Hospital Emergency Department's Clinical Coordinator and staff. The program staff also began preliminary discussions with Huggins Hospital to develop an expansion into the Huggins ED and were finalizing shared protocols to serve residents of Southern Carroll by the end of the reporting period.

A major impact to the Recovery Community this period has been North Country Health Consortium's (NCHC) announcement of their decision to seek another home for the SUD Clinical Services programs, including the residential programs at the Friendship House, after careful consideration by the Board of Trustees. The NCHC Board of Directors made this decision with a plan for full transition by the end of December 2020. NCHC reported that it has been a continuous challenge to cover costs for the high-quality services delivered, which was significantly magnified by the COVID-19 Pandemic. The Governor allocated CARES Act funding to NCHC that allowed the programs to remain open through the end of December, and NCHC worked with the State and the community to identify potential providers of these critical services in the North Country. NCHC formally ended operations at the Friendship House at the end of December, withdrawing from the Region 7 IDN in the process.

The building and grounds of the Friendship House remained the property of Region 7 IDN Partner AHEAD, Inc., and AHEAD has identified Amatus Health to provide services within the Friendship House building. At the time of this report, Amatus Health had signaled an intent to open detox, continue with 3.5 and 3.1 residential services, outpatient services and more. They stated a goal to have 100 days of treatment and then aftercare/outpatient for each client. Amatus Health currently has two locations in NH, and several others in a variety of states. They reported being in the process of expanding their Medicaid enrollment paperwork and applying for the residential license and noted that providing transportation is part of their business model. Region 7 IDN partners are anxious to see these services continue in the North Country and look forward to forging strong new relationships with Amatus Health as they establish their program in this part of the state, and workers displaced by the closure of NCHC operations were provided the opportunity to apply for openings Amatus Health anticipated having in their North Country program.

In the interim, the recovery resources that have flourished throughout the demonstration continue to exist and are accessible in the area. NCHC's Wellness and Recovery Model (WARM) will continue to connect those in need of recovery services with specially trained Community Health Worker/Recovery Coaches. In addition, NCHC's AskPETRA program is available by phone, text, and webchat at AskPETRA.org to share resources and connect people in need with treatment and recovery services in the area, at no charge. More resources are on the way with NCHC's newest grant to address Neonatal Abstinence Syndrome with outreach to pregnant women, mothers, and women of childbearing age who have a history of, or who are at risk for, Substance/Opioid Use Disorder (SUD/OUD).

Partner Specific Updates

Ammonoosuc Community Health Services (ACHS)

ACHS reports that they have been able to bring in staff during the reporting period, now having two full time behavioral health providers in addition to bringing on a part time Psychotic APRN to serve as the program's director and a consulting psychiatrist to assist with medication management needs. This partner has recently hired a full time LICSW who is planning to sit for their LDAC credential in January. The team is planning to take advantage of having an in-house LDAC and make their MAT program much more robust. The previously hosted SUD Coordinator position has not been refilled by ACHS, which has opted instead to strengthen partnerships with other recovery-focused teams in the community.

ACHS is also looking to expand their work on the school-based behavioral health services model by embedding another LCMHC in a new group of schools in early 2021. The newly hired LICSW will be providing coverage to the elementary school in Littleton where there previously has not been a behavioral health presence. This partner intends to leverage the Workforce Development & Integration funds offered through the Region 7 IDN transition plan to bring on another LICSW with systems background to drill down more on case management and help the team at ACHS operationalize the recommendations that come out of their multidisciplinary meetings. This position will be used to examine the cases of patients who are heavy utilizers of services and/or have the most comorbidities and find solutions for service connections that will make it easier for these patients to achieve their health-related goals.

During the reporting period, the ACHS clinician that had been serving the Crossroads integrated clinic hosted by Northern Human Services (NHS) took a position at another organization in the region, but ACHS remains committed to restaffing the position as soon as logistically possible. This partner's Director of Behavioral Health reports that, in addition to the hiring spree in her department, the

organization is looking at ways to expand her own direct partnership with Primary Care Providers in their own clinics as well. This has included her conducting real-time chart reviews between the regularly scheduled multidisciplinary meetings each month to provide more micro interventions more frequently. The team is working to maximize curb-siding and making the process of cross-disciplinary collaboration easier and more fluid, particularly for medication interventions and recommended referrals.

Carroll County Coalition for Public Health (C3PH)

While not a direct provider of services in the region, C3PH regularly reports the impact they see of the collaboration between Region 7 IDN partners in Carroll County. As noted elsewhere in this report, C3PH reports that they have seen significant workforce growth by some partners during the reporting period, while others have struggled to fill positions vacated just prior to the pandemic. They note that they have particularly seen workforce increase in the last half of the calendar year. Most notably, the work White Horse Recovery and Behavioral Health Services (WHR) and Mount Washington Valley Supports Recovery (MWVSR) has been doing to boost peer recovery supports in the Emergency Department (ED) setting which was initially funded by IDN has boosted capacity in Northern Carroll. This collaborative effort has expanded the model to Huggins during the reporting period, which C3PH reports as a significant gain for the county. While the crew of available recovery coaches is limited, it does represent increased access to recovery supports in the ED, and C3PH is hoping that the Carroll County SUD expansion project funded in the Region 7 IDN Transition Plan will successfully boost that pool of recovery coaches by December 2022.

C3PH reports that Cranmore Health Partners has emerged as a new urgent care provider in Conway, and while this practice is not a formal Region 7 IDN partner, their staff does include a provider who is waivered to provide MAT services to up to 100 patients. The region is also home to Blue Heron Neurofeedback and Counseling, which announced an expansion of services to include MAT and other outpatient SUD services in December. Blue Heron is also not a formal partner of IDN7, but has expanded capacity in Carroll County, the only county in the state of New Hampshire without a Doorway located within its borders. Finally, C3PH noted that MWVSR has signed a contract with the state to provide sober living housing for drug court participants during the reporting period, which is a service that lends additional capacity to the county.

Coös County Family Health Services (CCFHS)

CCFHS reports that they have had some churn in staffing of their behavioral health team during the reporting period. At present, they have two Psychiatric APRNs and two behavioral health counselors on staff. One is an MLADC that is pursuing dual licensure as an LCMHC, and the other is an LICSW. Both APRNs are involved in the MAT program and that continues with just over twenty people enrolled in the program, which is largely focused on pregnant or parenting women and their partners but does include others with opioid use disordered. CCFHS is currently participating in an initiative from the University of New Hampshire that is focused on Trauma Informed Care. Through this work, the staff are trying to integrate screening for Adverse Childhood Experiences (ACES) into the pediatric workflow. After approximately ten months on the project, CCFHS reports that they are starting to see substantial progress in the effort. This partner remains very mindful of the impact that COVID 19 is having on the mental health of everyone in the region. They report having seen an increase in relapse rates for people with substance use disorders, in addition to a general increase in the level of anxiety and depression that the general population is experiencing as well.

While typically very engaged in hosting health students, CCFHS reports that they have largely held off on students during the pandemic. They do have providers who remain extremely interested in having students back, though, so hope to restart internships and shadowing experiences in the fall of 2021.

Family Resource Center (FRC)

FRC reports that two valued Parent Partners moved on from the Strengths to Succeed team during the reporting period, one to a different program at FRC and another to an external organization. They shared that both changes were positive moves for the employees, but it did leave the program in Berlin searching for replacements during one of the busiest periods it has experienced to date. By the end of 2020, however, they had been able to fill both positions and hope to see the new staff members start in early 2021. In addition, they now have an opening at their Littleton location, but are very encouraged by the community response to openings, sometimes seeing up to twelve applicants in a single day.

FRC has also hired a Case Manager in the program to delegate some of the service coordination responsibilities away from the Parent Partners so that they can spend more time talking about recovery and mental health with their clients. The agency also continues to work on Medicaid enrollment and is working to get staff within the Strengths to Succeed program certified as CRSWs in order to have a sustainable reimbursement pathway for their services.

Huggins Hospital & Outpatient Practices

Huggins Hospital reports having a stable workforce through the reporting period. This partner notes that they have been leveraging contracted relationships to boost what they can offer to their patients, and have no positions open hat have been hard to fill. They report that they are currently working at a deficit across the board in the outpatient arena due to the extra processes put in place in response to the COVID pandemic, but this has not specifically impacted their behavioral health capacity.

Indian Stream Health Center (ISHC)

ISHC shared that during the reporting period the COVID pandemic continue to impact staffing significantly in their organization. By July, the behavioral health department was down to a single LICSW and the organization began looking at alternate models for connecting their patients to these services. Leveraging connections to former employees that had relocated to other states, ISHC was able to successfully engage a psychologist and an LICSW who were able to provide telehealth services to the clinic. ISHC adapted two offices in their building to serve as receiving sites for patients who have poor internet access in their homes but can attend telehealth sessions at the clinic. As this model was implemented, ISHC noted that visit volumes have increased on a weekly basis, and the work culminated in securing telehealth consultation services for primary care providers with a psychiatrist that provides medication management support for 5 hours each week.

Additionally, ISHC has been host to a behavioral health student who has served as a case manager, typically working with a caseload of ten patients at a time. This internship ends in the spring, so ISHC is in the process now of preparing to recruit for the position replacement. ISHC has noted that they are seeing an increase in young people really struggling with behavioral health during the COVID pandemic, in addition to the normally isolated elderly who are now even more isolated as they work to avoid potential exposure to the virus. In their deeply rural setting, internet connections are often challenging, and staff at the clinic worry that these elders may not be able to connect with their families electronically.

Littleton Regional Healthcare (LRH)

LRH reports that the last six months have been incredibly challenging. This partner lost approximately 40% of their workforce in furloughs resulting from the COVID pandemic, with losses in all areas including management, entry level staff, clerical supports, impacting complete service lines. Two APRNs relocated during the reporting period, and psychiatric support was reduced to limited telemedicine appointments with a local psychiatrist that serves several other partners in the region. Providers have been flexing hours and taking personal time off in order to remain available but in a reduced capacity that matched support staff levels.

LRH reports that the primary focus by the whole organization has been on the COVID response and keeping patients coming into the building and the workforce safe. As the reporting period began, significant effort was made to get patients in for routine and preventative care on reduced schedules that allowed for more time spent in COVID screening and cleaning exam rooms. There was a period during the transition when only extremely sick patients were seen, but new COVID testing protocols allowed for rapid screening of patients so that they could be seen in the building and receive preventative care services.

As a result of the COVID disruption, LRH staff report that they have only just begun to move the needle on social determinants screening and intervention. As reported in previous periods, screening tools were created in the electronic medical record (EMR), but uptake by providers was sporadic. In early 2021 the team will be implementing new templates in the EMR that will cue providers to assess all domains over time. As part of their work within an Accountable Care Organization, LRH is using the Athena platform for population health management and has mapped mandatory fields within their EMR to feed to Athena for analysis. This initiative has been on hold during the COVID response of 2020 but is anticipated to go live on February 1, 2021.

LRH also reports that their Care Coordinator role has been underutilized during the pandemic as the staff person in that role was repurposed to support providers through staff furloughs. This person still performs limited care coordinator tasks, including a daily review of emergency and inpatient admissions, but is primarily focused on daily operations within the primary care practice. Until staffing in the care coordination department can be increased, the team at LRH is finding it incredibly difficult to address opportunities highlighted in care gap reports.

Memorial Hospital

Memorial Hospital reports that they have not hosted any Behavioral Health students during the period due to a lack of clinicians to supervise their learning. The facility struggles with boarding behavioral health patients in the Emergency Department due to a lack of in-house services to work with them. Staff reports that, as a result of the economic impact of the COVID-related suspension of elective services earlier in the year, focus has been on reinvigorating services lines that better support the financial health of the organization first. The facility is performing COVID testing on more than 150 people per day and the full consumption of resources is focused on COVID response efforts.

North Country Health Consortium (NCHC)

NCHC serves as the home to a multitude of programs, including the Northern New Hampshire Area Health Education Center (NNH AHEC). **The NNH AHEC is actively engaged in delivering professional education to health providers in the rural region of Belknap, Carroll, Coös and Grafton Counties, and encouraging students to enter health careers in rural regions like this one. NNH AHEC is a provider of continuing medical and nursing education (CME/CNE) and retains a collaborative relationship with a**

number of providers of continuing education, allowing most educational offerings in the region to offer certified education credits for physicians, nurses, social workers, and substance use disorder treatment providers.

NNH AHEC successfully completed the self-study and interview process for reaccreditation of continuing medical education credits (CME) through October of 2024 through the New Hampshire Medical Society. This designation allows NCHC/ IDN 7 to provide quality continuing medical education that meets the guidelines for the Accreditation Council for Continuing Medical Education (ACCME). Many of the continuing education programs offered in the prior 4-year accreditation period have focused on the intersect of behavioral health and substance use as part of programming scheduled to meet the needs of the IDN. This has included offerings that increased capacity for MAT and improved pediatric access to behavioral health, such as the monthly live webinars "Partnership for Academic-Clinical Telepractice – Medications for Addiction Treatment (PACT-MAT)" and "New Hampshire Mental Health Care: in Pediatrics Project ECHO®."

NCHC/ IDN7 has also submitted an intent to re-apply for reaccreditation for continuing nursing education through the Northeast Multistate Division of the American Nurses Credentialing Center's Commission on Accreditation. The complete self-study application will be submitted March 1, 2021. NCHC/IDN 7 provides many continuing education programs for nursing professionals related to integrated delivery services including the monthly ECHO webinars mentioned in the CME accreditation section. During this reporting period NCHC/ IDN 7 provided 40 continuing education programs through live, live webinar or self-paced formats to a variety of interprofessional audiences in the region and across the state. Program audiences included physicians, nurses of all levels, behavioral health professionals, human service professionals and many others.

Northern Human Services (NHS)

NHS reports that during the last reporting period, despite all of the challenged posed by the COVID pandemic, the agency was able to become pretty close to fully staffed. This partner notes that it has been several years since the agency has been fully staffed across all offices, and it is remarkable to have only two openings for counselors. During the reporting period, NHS was also able to hire a regional intake coordinator that started in December in order to start addressing wait times and alleviating some compressed schedules. The Governor's executive orders under the COVID public health emergency has allowed the organization to utilize resources fully through telehealth models. It continues to be a struggle to psychiatry, which is an ongoing challenge across the state. NHS is willing to onboard both physician and APRN psychiatry providers should they be available. NHS has added a Care Liaison to staff under a contract with NAMI NH as part of the Garrett Lee Smith Suicide Prevention grant. The Care Liaison has completed Counseling on Access to Lethal Means (CALM) training and the CALM Trainer of Trainers module in order to be able to provide CALM training to staff.

In mid-December, the organization moved to having only a skeleton crew of staff working in their offices due to an increase of COVID cases in the region delivering only essential services in community while all other services were provide using telehealth modes. Rotations of staff were in the offices to cover Emergency Services and walk-ins, as well as those clients who struggle too much with the use of telehealth platforms like Zoom. Based on trends that are emerging during the pandemic, NHS shared that they may need to expand the children's department and their search for people willing to see children and families. Staff have noted an increase in the number of children who are struggling with isolation and the lack of normalcy that traditional school schedules bring – challenges that are then compounded or exacerbated by the adults in their lives struggling in similar ways. NHS has recognized

that there are both short-term and long-term mental health impacts of the prolonged COVID situation and is preparing to serve their community members in both instances.

NHS reports that they currently have two 2 clinicians in the Berlin office who are almost done with the process of becoming dually licensed, obtaining their MLADC in addition to their existing LCMHC credential, with two more working on LDAC hours. In 2021, NHS will be sending several case managers to the scheduled CHW training in order to bolster their skills. Unlike many other partners in the region, NHS has also continued to host interns and behavioral health students through the pandemic and has even received a request recently from a local high school student who is interested in shadowing behavioral health providers as part of a career exploration through the STEAM program. During the reporting period, NHS also leveraged staff meeting time to ensure that all behavioral health staff were trained in physical health issues so that the SAMHSA guidelines for multidisciplinary core team cross-training were met. Finally, staff have also undergone trainings from the managed care organizations on Motivational Interviewing and suicide prevention during the reporting period.

Rowe Health Center

During the reporting period, Rowe had an APRN student working in the clinic who has been introduced to the multidisciplinary collaboration between internal medicine and behavioral health providers. Staffing has essentially remained stable through the reporting period, with a potential LICSW candidate having been offered a position but unable to accept due to a lack of housing in the area. Rowe reports that lack of housing for professional candidates continues to be a recruitment issue – one that has been exacerbated during the pandemic as individuals and families able to telecommute have moved into rural communities in an effort to leave more urban settings with higher COVID case counts. Through support of the IDN Training & Technology funds, Rowe had planned a Trauma Informed Care training for staff to take place in the fall, but the scheduling was postponed as a result of COVID disruptions. The staff have leveraged some trainings using the online learning platform in the interim and the Trauma Informed Care sessions will take place in early 2021.

Saco River Medical Group (SRMG)

SRMG managed to stay completely staffed during the pandemic with the help of federal relief money. The practice experienced significant drops of patient volumes in early winter/spring that bounced back during the reporting period. SRMG does note, however, that their practice was able to maintain preventative care practices, vaccinations, and quality of care despite the pandemic.

Providers have moved to delivering a significant amount of telehealth in the last few months, with each family practitioner dedicating a day of telehealth each week from outside the office to decrease foot traffic onsite. During the reporting period SRMG lost one MAT provider but has continued to maintain a strong program with the remaining provider in the program. Two more providers obtained their X waivers and could add more capacity to the program, although SRMG notes that the waivers may be moot in light of recent federal changes in prescribing rules.

This partner has experienced significant turnover in nursing during the pandemic but maintain an overall staff of 56 personnel right now. This includes maintenance of their Enhanced Care Coordinator position through the reporting period. This staff person's time is largely consumed with the coordination of Transitional Care Management and Chronic Care Management for hospitalized patients and those recently seen in Emergency Departments. **The Care Coordination reports that they have seen an increase in services provided to individuals with mental health needs during the last reporting period.**

SRMG still depends entirely on outside organizations for mental health providers, maintaining strong relationships with Mount Washington Valley Psychiatric Services and NHS. SRMG also continues to work closely with Children Unlimited and NHS for patients with developmental needs. For recovery needs, SRMG is working closely with White Horse Recovery & Behavioral Health Services for hospital response and community outreach. While not formally using a Closed Loop Referral system, the fact that they do not have embedded behavioral health providers has incentivized SRMG to develop and maintain good lines of communication with their local partners. They report that these processes have significantly improved in the last 24 to 36 months, and SRMG providers now receive behavioral health notes regularly from external partners. At this time, the practice believes that this collaborative model is the most effective, given the barriers of limited financial opportunity to offer salaries competitive enough to secure a candidate and the lack of space they have at their current location. SRMG is interested in forming close connections with external Community Health Workers next, as well as finding a way to build consultation time for the family practitioners to meet with a psychiatrist from NHS regarding more challenging medication management cases.

Tri-County Community Action Program (TCCAP)

TCCAP reports that they have doubled the Critical Time Intervention (CTI) workforce during this reporting period by splitting each CTI position into a Case Manager position and an Outreach Coordinator for each of the counties. This reshaping of the Homelessness Intervention & Prevention team has allowed TCCAP to move a direct support worker from the region's only homeless shelter, The Tyler Blain House, to an Outreach Coordinator position in Coös in July, a Case Manager for Carroll in August and both a Case Manager and an Outreach Coordinator Northern Grafton in September & October. This new staffing model has allowed staff to focus in on one aspect of supporting folks with restabilizing their housing. The Outreach Coordinator works with individuals through the point of transitioning from pre-CTI to CTI phase one, which includes obtaining housing and moving in. At this point in the process, the Outreach Coordinator then provides the client with a warm handoff to the Case Manager who continues providing phased out case management services consistent with the CTI model.

White Mountain Community Health Center (WMCHC)

WMCHC has struggled to maintain staffing during the pandemic. The clinic's Medical Director has opened his own practice in the community, so now only available to WMCHC to provide medical direction remotely on a part time basis. This has resulted in a reduction of a clinician, in addition to several clinical support staff who have been unable to work as a result of childcare issues that surfaced during the pandemic. WMCHC reports that their ability to work remotely in a telehealth model has been significant in terms of being able to retain some staff members who would have been otherwise unable to continue working. Medical Assistants are not rooming as many patients in person, so have been able to take on more administrative work with patients via phone calls. WMCHC reports that they have been advertising open positions for three months with little uptake, noting that people in the healthcare professions are either burned out or significantly concerned about the health conditions of themselves and their loved ones that represent elevated risk for complications of COVID infection.

WMCHC also reports that they have not hosted any students during the reporting period, which they feel is a double-edged sword. On the one hand, they have always been very committed to supporting workforce development and have several providers who strongly feel their duty to help train the next generation of health professionals. On the other hand, the practice lacks physical space to adequately support physical distancing and do not believe that their current situation would provide a strong learning experience for willing students. WMCHC was pleased to report, however, that when their

dental program suspended operations during the pandemic, one of the dental assistants began helping out in a medical assistant capacity and has since decided to pursue education to become a Certified Medical Assistant. WMCHC values these "grow your own" opportunities and is looking forward to leveraging the Workforce Development & Integration funds from the Region 7 IDN Transition Plan to provide supports for professional development among their staff.

Staffing All Projects

Provide the IDN's projected and **current number of full-time equivalent** (FTE) staff **related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community-driven projects**. This table should be the sum of all **statewide and community-driven projects** and also include any IDN administrative staff.

As noted in the Project Plan Implementation (PPI) section of this report, many partners in Region 7 have dedicated considerable time and effort during the reporting period working to ensure that their most vulnerable patients and clients remained connected to services. As a result of COVID-related disruptions, not all partners have been able to dedicate time to producing quantitative data that informs this report, or to sharing detailed narrative reports of their work. Reporting gaps remain, so some of the performance target aggregate totals may have decreased over the last two reporting periods. These regressions may reflect staffing losses and reductions or be the result of incomplete data sets.

Provider Type	IDN Workforce (FTEs)						
	Project(s)	Projected Total Need By 12/31/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20	Staffing on 12/31/20
Master Licensed Alcohol and Drug Counselors	A1, B1, D3	16	14	17	18	16	11
Licensed Mental Health Professionals	A1, B1	23	9	49	45	41	43
Peer Recovery Coaches	A1, B1, D3	6	67	88	88	107	107
Other Front-Line Provider	A1, B1	1	52	42	39	41	58
Behavioral health assistant (round 1 funds for baseline 6/30/17)	A1, B1	1	4	4	5	3	5
Behavioral health case managers (round 1 funds for baseline 6/30/17)	A1, B1	5	7	49	51	45	45
Care Advocate Supervisors	A1, B1, E5	1	1	2	2	3	2
Care Advocates	A1, B1, E5	15	11	21	18	19	18
Case Management	A1, D3	2	15	67	66	69	62
Community based clinician (round 1 funds for baseline 6/30/17)	A1, B1	1	1	1	1	1	1
Community nurse coordinator (round 1 funds for baseline 6/30/17)	A1, B1	1	1	1	1	1	1
Community Health Workers	A1, B1, D3, E5	4	13	18	19	17	12
CTI Supervisors	A1, B1, C1	3	3	5	4	3	2
CTI Workers	A1, B1, C1	15	37	37	36	40	39
Data Specialists for IDN partners	A1, B1	Up to 3	3	9.4 FTE + 3 contracted data aggregators	8.65 FTE + 3 contracted data aggregators	8.65 + 3 contracted data aggregators	13
HIT Integration Coach	A1, A2, B1	1	1	1	1	0	0

Provider Type	IDN Workforce (FTEs)						
	Project(s)	Projected Total Need By 12/31/18	Staffing on 12/31/18	Staffing on 6/30/19	Staffing on 12/31/19	Staffing on 6/30/20	Staffing on 12/31/20
IDN Data Specialist (NCHC)	A1, B1	1	1	1	1	1	1
IDN QI Coach	A1, B1	1	2	2	1	1	1
LICSW (round 1 funds for baseline 6/30/17)	A1, B1	3	4	13	10.5	17	18
Physician assistant (round 1 funds for baseline 6/30/17)	A1, B1	1	3	17	18	14	17
Psych Nurse Practitioners (round 1 funds)	A1, B1, D3	3	7	11	11	10.5	10.5

As noted in the Project Plan Implementation (PPI) section of this report, many partners in Region 7 have dedicated considerable time and effort during the reporting period working to ensure that their most vulnerable patients and clients remained connected to services. As a result of COVID-related disruptions, not all partners have been able to dedicate time to producing quantitative data that informs this report, or to sharing detailed narrative reports of their work. Reporting gaps remain, so some of the performance target aggregate totals may have decreased over the last two reporting periods. These regressions may reflect staffing losses and reductions or be the result of incomplete data sets. Additionally, as reporting in the previous Semi-Annual Report, Region 7 IDN has experienced the reduction of a Health Information Technology (HIT) Integration Coach, which was focused on assisting partner organizations with their adoption of HIT infrastructure that aids integration efforts. This position was eliminated because the remaining workload for the HIT Integration Coach was steadily decreasing as partners signaled that they had reached their capacity limits for further HIT implementation, particularly in the context of their own staffing shortages during the pandemic. The remaining workload of this position could be absorbed by the IDN Data Specialist and the IDN Program Manager for the remainder of the demonstration. In this way, the functionality of the position remains intact while decreasing staffing costs for the region.

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the workforce capacity development implementation plan which must include financial reporting on actual spending to recruit, hire, train, and retain the workforce. In your narrative please also speak to any variances from your proposed cost to your actual spending.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	1/1/2019 - 12/31/2019	1/1/2020-6/30/2020	7/1/2020-12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
Workforce	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June ACTUAL	CY 2020 July to Dec ACTUAL	CY 2020 ACTUAL	CY 2021 Projected
Line Item	Total								
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants									
5. Supplies:									
Educational									
Office	$ 2,916	$334	$350	$286	$636	$220	$60	$280	$114
6. Travel	$ 2,233	$1,981	$610	$610	$1,220	$132	$284	$416	$284
7. Occupancy									
8. Current Expenses									
Telephone									
Postage									
Subscriptions									
Audit and Legal									
Insurance									
Board Expenses									
9. Software		$1,334	$718	$1,164	$1,882	$405	$341	$746	$285
10. Marketing/Communications	$ 3,272	$7,138	$539	$579	$1,118	$51	$3	$54	$27
11. Staff Education and Training		$3,334	$820	$820	$1,640	$567	$199	$766	$199
12. Subcontracts/Agreements									
13. Other (specific details mandatory):									
Current Expenses: Administrative Lead Organizational Support	$ 4,923	$4,066	$887	$828	$1,715	$477	$276	$752	$264
Support Payments to Partners	$ 198,135	$312,588	$80,492	$124,788	$205,280	$27,264	$51,803	$79,067	$294,312
TOTAL	$ 277,087	$424,149	$152,906	$186,244	$339,150	$74,225	$89,254	$163,479	$318,764

At the beginning of the demonstration, Region 7 opted to take the approach of budgeting based on how incentive payments are earned. This approach has been used for staffing as well as partner requests for funds and was adopted because partner proposals and staff time often touch multiple DSRIP projects concurrently. Expenses have therefore been allocated as a flat percentage across project areas, with the region setting out initially to roughly budget the funding across projects in parallel to the proportions in which the incentive payments were earned.

As funding uncertainties mounted in 2018 and 2019, the region maintained the original allocation rather than making the shift in the weighting from the state-wide projects to the core competency project. This has resulted in allocations of approximately 42% of funding to state projects, 36% to the core competency project and 22% to community projects for the life of the DSRIP. Proposed expenses for the remainder of the demonstration include anticipated costs for infrastructure staffing, subscription to the Collective Medical Network and distribution of remaining earned incentive payments to partner organizations in support of their ongoing work to meet the goals of the DSRIP. Variances experienced to date include:

- Reductions in incentive payments available following decreased county contributions for years 3 and 4.
- Failure of the region to meet 100% of incentive payment targets for both process and performance measures.
- The restructuring of infrastructure staffing in line with decreased funding earned by the region, the rationale being that if there was less money available for partner organizations, the infrastructure team should be similarly reduced.

A1-7 IDN-level Workforce: Table of Key Organizational and Provider Participants

Use the format below to provide an **updated list of key organizations** and providers participating in the IDN to support workforce development within the reporting period. Include and note workforce related to the IDN HIT Infrastructure, IDN Integrated Healthcare, and the IDN selected community projects.

Organization Name	Organization Type	Associated with IDN Projects (A1, A2, B1, C, D, E)
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, D3, E5
Androscoggin Valley Hospital	Hospital Facility	A1, A2
Carroll County Department of Corrections	County Corrections Facility	A1, A2, C1
Children Unlimited	Community-based Organization providing social and support services	A1
Coös County Department of Corrections	County Corrections Facility	A1, D3
Coös County Family Health Services	Federally Qualified Health Center (FQHC)	A1, A2, B1, D3, E5
Cottage Hospital	Hospital Facility	A1, A2
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services	A1
Family Resource Center, Gorham	Community-based Organization providing social and support services	A1, C1
Grafton County Nursing Home	Skilled nursing	A1
Hope for NH Recovery	Peer Recovery	A1, D3
Huggins Hospital	Primary Care Practice; Hospital Facility	A1, A2, B1, D3, E5
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services	A1, A2, B1, E5
Life Coping, Inc.	Community-based	A1
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic	A1, A2, B1
Memorial Hospital	Hospital Facility	A1, A2, B1, D3, E5
Mount Washington Valley Supports Recovery	Peer Recovery, Transitional Housing	A1, D3
North Country Health Consortium (NCHC), NCHC Clinical Services & Friendship House	Substance Use Disorder Treatment (After 10/01/2017), Community-based Organization providing social and support services	A1, A2, B1, D3, E5
North Country Serenity Center	Peer Recovery	A1, D3
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services	A1, A2, B1, D3, E5
Rowe Health Center	Rural Health Clinic **(under cottage hospital)**	A1, A2, B1
Saco River Medical Group	Rural Health Clinic	A1, B1
Tri-County Community Action Program	Community-Based Organization	A1, C1
Upper Connecticut Valley Hospital	Hospital Facility	A1, A2
Visiting Nurse Home Care & Hospice	Skilled nursing, home health, homemaker	A1
White Horse Addiction Center	Substance Use Disorder Provider, Therapy for co-occurring disorders (mental health and substance use disorders); Recovery Resources, Advocacy and Support.	A1, A2, B1, D3
White Mountain Community Health Center	Non-FQHC Community Health Partner	A1, A2, B1, D3, E5
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic	A1, A2, B1, D3, E5

Project A2: IDN Health Information Technology (HIT) to Support Integration

Narrative

Provide a detailed narrative which lists every participating provider at the practice site level and the progress made/activity during the reporting period.

Network Membership

During the reporting period of July 1 through December 31, 2020, one partner, NCHC Clinical Services/Friendship House, left the network, bringing the total number of partners in the Region 7 IDN to thirty-eight (38). The information below speaks to the progress that Region 7 IDN has made on the A2 project "IDN Health Information Technology (HIT) to Support Integration" during this reporting period.

Key organizational and provider participants

This table represents only the subset of partners who are participating in the A2: IDN Health Information Technology (HIT) to Support Integration project. It is therefore a subset of the partners listed in the larger group represented in the IDN-level Workforce: Table of Key Organizational and Provider Participants presented in the A1: Behavioral Health Workforce Capacity Development section of this report.

Organization Name	Organization Type
Ammonoosuc Community Health Services	Federally Qualified Health Center (FQHC)
Androscoggin Valley Hospital	Hospital Facility
Carroll County Department of Corrections	County Corrections Facility
Children Unlimited	Community-based Organization providing social and support services
Coös County Department of Corrections	County Corrections Facility
Coös County Family Health Services	Federally Qualified Health Center (FQHC)
Cottage Hospital	Hospital Facility
Crotched Mountain Foundation	Hospital Facility; Community-based organization providing social and support services
Family Resource Center, Gorham	Community-based Organization providing social and support services
Grafton County Nursing Home	Skilled nursing
Hope for NH Recovery	Peer Recovery
Huggins Hospital	Primary Care Practice; Hospital Facility
Indian Stream Health Center	Federally Qualified Health Center (FQHC); Substance Use Disorder; Non-CMHC Mental Health Provider; Community-based Organization providing social and support services
Life Coping, Inc.	Community-based
Littleton Regional Healthcare	Hospital Facility; Rural Health Clinic
Memorial Hospital	Hospital Facility
Mount Washington Valley Supports Recovery	Peer Recovery, Transitional Housing
North Country Health Consortium (NCHC), NCHC Clinical Services & Friendship House	Substance Use Disorder Treatment (After 10/01/2017), Community-based Organization providing social and support services
North Country Serenity Center	Peer Recovery

Organization Name	Organization Type
Northern Human Services	Substance Use Disorder Provider; Community Mental Health Center (CMHC); Community-Based Organization Providing Social and Support Services
Rowe Health Center	Rural Health Clinic **(under Cottage Hospital)**
Saco River Medical Group	Rural Health Clinic
Tri-County Community Action Program	Community-Based Organization
Upper Connecticut Valley Hospital	Hospital Facility
Visiting Nurse Home Care & Hospice	Skilled nursing, home health, homemaker
White Horse Addiction Center	Substance Use Disorder Provider, Therapy for co-occurring disorders (mental health and substance use disorders); Recovery Resources, Advocacy and Support.
White Mountain Community Health Center	Non-FQHC Community Health Partner
Weeks Medical Center	Primary Care Practice; Hospital Facility; Rural Health Clinic

Performance Metric Reporting

This table represents only the subset of partners who have a reporting responsibility under the statewide outcome measures. If a partner is on the key organizational list but not represented here, they were not part of the measure collection effort because the measures specifications did not apply to them.

Provider	Reporting Status by Reporting Period							
	Period 1	Period 2	Historical File Submission 10/15	Period 3	Period 4	Period 5	Period 6	August and October 2020 Requests
Ammonoosuc Community Health Services	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Androscoggin Valley Hospital	*	*	*	*	Did not report	*	*	*
Coös County Family Health Services	Did not report (held data back because of 42 CFR Part 2 concerns)	Complete	Complete	Complete	Complete	Complete	Complete	Complete
Cottage Hospital/Rowe Health Center	Did not report	Partial	Complete	Complete	Complete	Complete	Complete	Complete
Friendship House	Did Not Report	Did Not Report	No patients in sample	Complete	N/A	Complete	Complete	N/A
Huggins Hospital	Partial	Partial	Did Not Report	Complete	Complete	Complete	Complete	Complete
Indian Stream Health Center	Complete	Complete	Complete	Complete	Did not report	Did Not Report	Did Not Report	Complete
Littleton Regional Healthcare	*	*	*	*	Did not report	Complete	Complete	Complete
North Country Healthcare	Did Not Report	Did Not Report	Did Not Report	Partial	Partial	Partial	Complete	Complete
Northern Human Services	Did Not Report	Complete	Complete	Complete	Complete	Complete	Complete	N/A
Memorial Hospital	Partial	Did Not Report	Did Not Report	Complete	Complete	Complete	Complete	Complete

Provider	Reporting Status by Reporting Period							
	Period 1	Period 2	Historical File Submission 10/15	Period 3	Period 4	Period 5	Period 6	August and October 2020 Requests
Saco River Medical Group	Did Not Report	Complete	Complete	Complete	Partial	Complete	Partial	Complete
Upper Connecticut Valley Hospital	*	*	*	*	*	*	*	*
Weeks Medical Center	*	*	*	*	*	*	*	*
White Horse Addiction Center	Did Not Report	Did Not Report	No patients in sample	Complete	N/A	Complete	Complete	N/A
White Mountain Community Health Center	Complete	Complete	Complete	Complete	Complete	Complete	Complete	Complete

*These partners reporting under the North Country Healthcare (NCH affiliation). LRH was part of the affiliation until 2Q 2019, at which point they began reporting directly to the IDN.

The period covered in this report was a time of great difficulty for IDN 7 partners and the effects of these challenges were felt keenly in the area of HIT/Data work. With the arrival of the COVID-19 pandemic and its distorting effect on the region's systems, many projects that were planned for this time period were de-prioritized. In addition, several reporting requirements that would have been the focus of this period were removed in response to the Pandemic, reporting efforts shifted to focus on the data requests received from the state in late summer and fall to fill gaps in calendar year 2018 and 2019 data. This request was focused on the CARE-03 A, CARE-03 C sub-measures as well as the ASSESS_SCREEN.03 composite measure. IDN Region 7, after speaking with partners about capabilities, soon discovered that the ability to report on the ASSESS_SCREEN.03 measure was not present in several key partners, leading Region 7 to make the hard decision not to ask for historical/gap reporting on this measure from any partners because of the all-or-nothing method of determining whether a region had met the measure. Per guidance from the state, this method of approach was acceptable. In all other areas, region 7 strove to complete all reporting and it was only on this one measure, in the face of partner staffing shortfalls secondary to the pandemic, that such a hard decision was made. As the elements focused on in the A2 plan are supporting elements for coordinated care and integrated care designation, our narrative focuses only on those partners who are moving towards coordinated care or integrated care designations.

Partner Specific Updates

Ammonoosuc Community Health Services (ACHS)

ACHS completed all necessary reporting requested of them in this period, reporting fully on the historical data requests due in August and October (focused mainly on the CARE-03 measures). They reported that completing this reporting was much easier than previous asks due to the provision of denominator patients by the state.

ACHS was also an active user of the Collective Medical Technologies network (CMT) during this time, uploading their census files diligently and continuing to use the tool on a monthly basis.

ACHS has also been working on systems integration with local hospitals in order to help assure a more seamless transition into different care settings. They are hoping to utilize a relationship to Athena to

put into action some of the information they have gleaned around heavy utilizers. They are also piloting a patient portal with provider engagement tools built in.

Coös County Family Health Services (CCFHS)

Coös County Family Health Services responded and reported fully on both historical requests in 2020. They, like ACHS, reported a greater ease in responding to the CARE.03 focused portion because of the provided denominator cutting out a potentially time-consuming step of identifying patients.

CCFHS has also reported that while they continue to use CMT, staff previously assigned to this task have been diverted to contact tracing and follow-up related to COVID-19. They report some early internal data that hospital readmissions have increased because of this change in focus.

CCFHS has also been a partner to have had a direct secure messaging solution throughout the project. They report it to be used infrequently. In the reporting period, they did institute a secure texting solution for staff to communicate, something reported to be extremely useful in facilitating internal communications.

Like other partners, they have shifted to a telehealth stance in the pandemic, with the attendant challenges and opportunities experienced elsewhere. A major challenge reported by Coös is the poor broadband infrastructure serving the largely rural general population of the region. It presents a major barrier to a long-term shift to this type of care, which otherwise would be a good fit for a geographically dispersed population. They have had more success on enabling providers for this change, deploying a tool called “Virtual Scribe” which allows providers to securely communicate information into their Centricity EHR via a secure third-party service.

Huggins Hospital

Huggins fully reported on the historical files due in August and October. Like others, they reported that having the denominator patients saved them considerable time abstracting the data compared to prior reporting periods.

Huggins was one of the early adopters in-region of CMT and continues to use it frequently. They are exploring a Unite Us implementation to help complement their care coordination activities, specifically with their referral-focused staff who are already using other, potentially non-closed-loop methods to achieve the same goals.

Indian Stream Health Center (ISHC)

As has been reported in previous reports, ISHC has been faced with an IT staffing shortfall, leading to their non-participation in several recent A2-Focused activities. This has been further complicated by available resources being dedicated to an implementation of EHR systems upgrades that took place at ISHC over CY 2020. One of these upgrades is the additional of several fields for Social Determinant of Health indicators, and they hope to utilize these new fields to serve an effort to work closer with behavioral health providers.

Nevertheless, they reported fully on the two data requests around the CARE.03 measures during the reporting period, leveraging a relationship with another partner (Androscoggin Valley Hospital) for assistance in running the reports)

ISHC continues to utilize CMT as a tool for their Care Management Nurses to gain visibility into patient visits to outside-of-region facilities. They report their visibility into patient visits to in-region partner hospitals like Upper Connecticut Valley Hospital was already in place through other means.

Littleton Regional Healthcare

LRH had reported staffing reductions in their IT teams related to the pandemic in the previous reporting period. This caused them to be unable to meet several IDN goals, including reporting in previous periods (particularly the request for supplementary reporting in March 2020) and any progress to integrating LRH with CMT.

However, while the staffing reductions to continue to impact their teams, LRH was able to successfully report on the CARE.03 data for 2018 and 2019 requested in the second half of 2020. Region 7 is greatly appreciative of the effort put forth by LRH to fulfill these requests, despite being short-staffed.

Memorial Hospital

Memorial reported fully on both data requests during this period, continuing their trend of full reporting.

Unfortunately, Memorial, due to their status as a subsidiary of the larger Maine Health system, has not been able to engage in the sending of ADT data to Collective Medical, remaining one of two regional hospitals to have not taken this step. They report being able to notify partners of patient visits in other pathways through their EHR, Epic. Feedback from other partners seems to indicate this effort is having a positive effect.

Like other hospital partners, they have been affected significantly by COVID-19, which has sidelined many of their population-health focused initiatives in favor of the more immediate concerns.

North Country Health Consortium – Friendship House

Friendship House fulfilled all reporting requirements in CY 2020 and like other BH providers, were not included on the supplementary requests of August and October 2020. Friendship House had been exploring a CMT implementation early in the year, only to put it on hold due to the disruptions caused by the pandemic. Friendship House ceased operations in December 2020.

Northern Human Services (NHS)

NHS reported fully in this period, not being included in the 2018 and 2019 CARE.03 request. They report the majority of their IT resourcing is being focused on shifting to telehealth. They have begun to explore Unite Us and believe it may be helpful.

NHS continues to use CMT for receiving notifications, though they have not yet made the step of uploading care plans. They report it would be easier to achieve provider buy-in and meet measures around 7 and 30 day follow up when NH Hospital and other discharging facilities are on the system.

Rowe Health Center/Cottage Hospital

Cottage reported fully on the two data requests in the reporting period. As with other partners, they report an ease of reporting because of the provision of the denominator. Cottage Hospital was a recent addition to the CMT network, as they began sending ADT into the system around mid-year 2020.

Like ACHS, Rowe has been using capabilities in their Athena EHR to help assure continuity of services between physical health and behavioral health arms of their organization, leading to reported better patient outcomes in the area of patient safety. Rowe also reports leveraging aspects of Athena to help with referral warm-handoffs and close-looped referrals. They continue to use fax processes for outside entities and leverage their patient portal for patient engagement.

Saco River Medical Group (SRMG)

Saco River saw this period dominated by their implementation of a new EHR system, Athena. They report this was a major undertaking for them, but one that has begun to yield benefits in the form of improved reporting and lightened workload on staff previously tasked with abstraction. Much of the staff's efforts were focused on that implementation through the summer, bringing on board some direct integration with Memorial's EPIC platform. SRMG now has file sharing with Memorial for shared patients and the systems trade notifications directly. This is borne out in their quick and efficient performance on reporting in this period, reporting fully on both the 2018 and 2019 CARE.03 requests.

A CMT implementation was put on hold by re-allocation of resources to the EHR implementation and the pandemic. They report being able to achieve many goals around patient visibility locally with Memorial through other means.

Like Rowe and ACHS, Saco River has begun to utilize features of Athena to support closed-loop referral and patient engagement goals. Like Rowe and ACHS, they have achieved early success in these areas.

SRMG continues to use direct secure messaging, but find it limited by inconsistent uptake across their wider range of partners.

White Horse Recovery & Behavioral Health Services (WHR, formerly White Horse Addiction Center)

White Horse Recovery reported fully in 2020, and like other behavioral health providers, were not included in the August and October supplementary reporting requests. WHR did not share updates on plans around HIT during this period.

White Mountain Community Health Center

WMCHC reported fully on the CARE.03 measures, continuing their run as one of our most consistent reporting partners.

WMCHC, like our other Carroll County partners, report receiving information regarding patient visits from Memorial outside of CMT, filling a local visibility gap that had previously existed. They continue to use CMT for visibility on visits to non-Memorial partners.

A previous round of IDN-related funding had allowed WMCHC to purchase UpDox, a tool that includes telehealth and patient engagement capabilities. They report this being extremely helpful to operations during the pandemic, not only to set up appointments remotely, but also to provide testing guidance and contact tracing services.

Weeks Medical Center

Weeks Medical continues to use send ADT to CMT and utilize the tool in their emergency department.

Weeks also fulfilled all reporting requests in the reporting period, responding quickly and effectively to the CARE.03 data request in August and October. They report a greater ease of reporting due to the denominator patients being provided in advance.

As with partners Upper Connecticut Valley Hospital and ISHC, Weeks has dedicated significant efforts during this reporting period to the implementation of a new EHR, Meditech.

Evaluation Project Targets

From the IDN HIT Implementation Plan, use the format below to identify the progress toward targets, or goals, that the plan has achieved.

As noted in the Project Plan Implementation (PPI) section of this report, many partners in Region 7 have dedicated considerable time and effort during the reporting period working to ensure that their most vulnerable patients and clients remained connected to services. As a result of COVID-related disruptions, not all partners have been able to dedicate time to producing quantitative data that informs this report, or to sharing detailed narrative reports of their work. Reporting gaps remain, so some of the performance target aggregate totals may have decreased over the last two reporting periods. These regressions may reflect staffing losses and reductions or be the result of incomplete data sets.

Performance Measure Name	Target	Progress Toward Target				
		As of 12/31/18	As of 6/30/19	As of 12/31/19	As of 06/30/20	As of 12/31/20
Participant sites with at least one staff member trained in use of PreManage Primary	13	3	8	8	8	8
Number of Participants Exchanging Information Via Shared Care Plan Tool	13	3	8	8	8	8
Hospitals Sending Event Notifications to PreManage ED	7	4	4	4	5	5
Number of Participants Exchanging Information Via Direct Secure Messaging (By 2020)	35	10	**10**	10	10	10
Reporting Periods Successfully Completed (By 2020)	11	3	5	6	7	9
Pilot Participants Using Population Health Tool (By 2020)	5	0	8	8	8	8
Region 7 Patient Lives in PreManage Primary (By 2020) – includes any patient on the census upload	19,601	15,273	57,998	30,024*	59353	72356
Participant HIT Projects Addressing Minimum/Desired/Optional Capabilities Funded and Completed (By 2020)	5	8 (22 funded or provisionally funded)	11	13	13	13

**Due to a limitation in the January 2020 Collective Medical Report, Huggins Hospital patients were incorrectly excluded from this number. This has been corrected in the report run for the first half of 2020.*

As requested, the following table has been added to this section to aid in consideration of incentive payments based on partially met sections of this report. The Region 7 IDN team populated the table as follows:

- Event Notifications reflects partners actively receiving notifications in the Collective Medical (CM) network
- Shared Care Plan reflects partners exchanging information on the CM network, including both in feeding and receiving data to populate the event notification service.
- Closed-Loop Referral reflects partners who meet the criteria for closed loop referral within the Core Competency Integrated Healthcare project. The remaining partners are all implementing closed loop referral workflows but were not counted because their processes are either in draft or being tested with pilot locations.
- Data Reporting reflects partners who have submitted Statewide Outcome Reporting data to MAeHC.

- Data Sharing reflects partners who have data use agreements in place.
- Care Coordination reflects those partners who meet the criteria for electronic sharing of some clinical data related to treatment, diagnosis, and care management within the Core Competency Integrated Healthcare project. During this reporting period, the remaining partners reported using manual processes to share this information with other members of the patient/client care circle.

Performance Measure Name	# of Participating Practices	Progress Toward Target				
		As of 12/31/18	As of 6/30/19	As of 12/31/19	As of 6/30/2020	As of 12/31/20
Event Notification Services	13	3	7	7	7	7
Shared Care Plan	13	3	10	10	10	11
Closed Loop Referral	13	9	10	10	10	10
Data Reporting	13	13	13	12	12	13
Data Sharing	13	13	13	13	13	13
Care Coordination	13	10	11	12	12	12

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the IDN HIT project which must include financial reporting. In your narrative please also speak to any variances from your proposed cost to your actual spending.

Budget Period:	01/01/2018-06/30/2018	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	01/01/2019-12/31/2019	1/1/2020-6/30/2020	7/1/2020-12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
HIT		CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June ACTUAL	CY 2020 July to Dec ACTUAL	CY 2020 ACTUAL	CY 2021 Projected
1. Total Salary/Wages										
2. Employee Benefits										
3. Consultants										
5. Supplies:										
Educational										
Office	$6,127	$1,612	$265	$194	$158	$352	$122	$33	$155	$63
6. Travel	$10,107	$1,235	$1,095	$337	$337	$674	$73	$157	$230	$157
7. Occupancy										
8. Current Expenses										
Telephone										
Postage										
Subscriptions	$74,991		$221,755	$102,146	$77,730	$179,876	$47,372	$42,368	$89,740	$0
Audit and Legal										
Insurance										
Board Expenses										
9. Software	$421		$738	$397	$643	$1,040	$224	$188	$412	$158
10. Marketing/Communications	$506	$1,809	$4,501	$298	$320	$618	$28	$2	$30	$15
11. Staff Education and Training	$12,633		$1,849	$453	$453	$906	$313	$110	$423	$110
12. Subcontracts/Agreements										
13. Other (specific details mandatory):										
Current Expenses: Administrative Lead Organizational Support	$1,989	$2,722	$2,246	$490	$458	$948	$264	$152	$416	$146
Support Payments to Partners	$16,111	$109,551	$171,518	$44,481	$68,959	$113,440	$15,067	$28,627	$43,693	$162,640
TOTAL	$166,218	$ 153,205	$511,463	$186,644	$180,650	$367,294	$88,389	$91,691	$180,080	$176,152

At the beginning of the demonstration, Region 7 opted to take the approach of budgeting based on how incentive payments are earned. This approach has been used for staffing as well as partner requests for funds and was adopted because partner proposals and staff time often touch multiple DSRIP projects concurrently. Expenses have therefore been allocated as a flat percentage across project areas, with the region setting out initially to roughly budget the funding across projects in parallel to the proportions in which the incentive payments were earned.

As funding uncertainties mounted in 2018 and 2019, the region maintained the original allocation rather than making the shift in the weighting from the state-wide projects to the core competency project. This has resulted in allocations of approximately 42% of funding to state projects, 36% to the core competency project and 22% to community projects for the life of the DSRIP. Proposed expenses for the remainder of the demonstration include anticipated costs for infrastructure staffing, subscription to the Collective Medical Network and distribution of remaining earned incentive payments to partner organizations in support of their ongoing work to meet the goals of the DSRIP. Variances experienced to date include:

- Reductions in incentive payments available following decreased county contributions for years 3 and 4.
- Failure of the region to meet 100% of incentive payment targets for both process and performance measures.
- The restructuring of infrastructure staffing in line with decreased funding earned by the region, the rationale being that if there was less money available for partner organizations, the infrastructure team should be similarly reduced.

Project B1: Integrated Healthcare

Narrative

Include a detailed narrative which lists every participating provider at the practice **site** level and the progress made during the reporting period toward the Integrated Care Practice Designation. This should be **a detailed summary of where they are including what has been done, what has not yet been done**, the number of participating individuals, major accomplishments, barriers, and setbacks.

Integrated Care Practice must include:

- Medication-assisted treatment (MAT)
- Evidence-based treatment of mild-to-moderate depression within the Integrated Practice setting either (e.g., IMPACT or another evidence-supported model)
- Enhanced use of technology

Network Membership

During the reporting period of July 1 through December 31, 2020, one partner, NCHC Clinical Services/Friendship House, left the network, bringing the total number of partners in the Region 7 IDN to thirty-eight (38). Information in the sections below speaks to the progress that Region 7 IDN has made on the B1 Core Competency project "Integrated Healthcare" during this reporting period.

Key organizational and provider participants

Organization/Provider	Agreement Executed (Y/N)
Ammonoosuc Community Health Services	Y
Coös County Family Health Services	Y
Cottage Hospital/Rowe Health Center	Y
Friendship House/North Country Health Consortium	Y
Huggins Hospital	Y
Indian Stream Health Center	Y
Littleton Regional Healthcare	Y
Memorial Hospital	Y
Northern Human Services	Y
Saco River Medical Group	Y
Weeks Medical Center	Y
White Horse Addiction Center	Y
White Mountain Community Health Center	Y

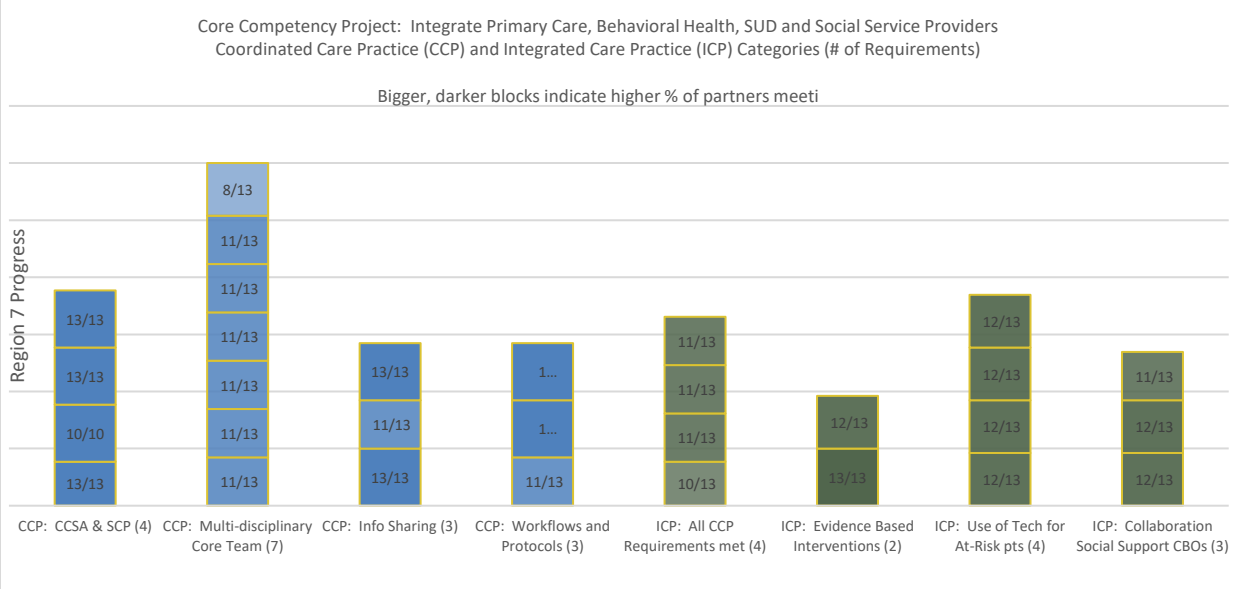
Progress Along the Continuum of Coordinated to Integrated Care

While the Region 7 IDN has not yet met its goals of having nine partners reach integrated health care status and all 13 partners reach coordinated care status, the region does continue to make progress along the continuum. Despite the significant disruption of the COVID pandemic during this reporting period, the region's partners have continued to focus on maintaining and improving internal processes to ensure that their patients and clients are well supported, receiving patient centered, whole-person care. A particular trend in reports from partners across the region is their awareness of elevated mental health needs across not only patients with diagnoses of behavioral health disorders, but their general

patient/client population, largely due to the stresses of living in a pandemic rife with uncertainty, conflicting guidance regarding personal safety and extended periods of isolation. Many partners have signaled a concern of a "second pandemic" of mental and emotional distress that is starting to emerge. Partners have expressed a desire to intervene early when patients and clients present with signs and symptoms of detrimental stress in an effort to mitigate long-term negative impacts of the pandemic on the mental health of our communities.

Although six practices still have unmet criteria in both the coordinated care and integrated care practice categories, they have all made progress along the continuum and several are likely to reach at least coordinated care practice by the end of the demonstration. A number of practices that had previously struggled with the adoption of protocols related to multidisciplinary core teams did adopt the Region 7 IDN protocol at the beginning of the year and are primed to move forward with either internal teams, or collaboration with other partners, as soon as the demands of COVID response subside. In many cases, there is a habit of integrated care delivery that needs to be formalized and codified through the development of policies and protocols that can be used to train inexperienced staff and maintain the commitment to delivery system reform. In others, partners are implementing changes that meet the spirit of the requirements of the SAMHSA framework for coordinated and integrated care, even if some interventions don't meet the specific guidance set forth within. A primary example of this adaptation is the significant increase of Psychiatric APRNs, rather than Psychiatrists, throughout the region. In the state of New Hampshire, APRNs are recognized as independent practitioners. They are also more numerous, and partners have had some early success using a "grow your own" approach to supporting the development of RN staff into board-certified Psychiatric APRNs – a model that circumvents lengthy and expensive recruitment and relocation processes undertaken when positions are filled by external candidates.

The graph below provides a snapshot of the current state of the Region 7 IDN partners' progress on each of the requirements of Coordinated and Integrated Care Practice status. In this graph, each column represents a category of requirements for the Coordinated Care Practice (CCP) (in blue) and Integrated Care Practice (ICP) (in green) status as outlined in the Special Terms and Conditions. Each block within the column represents a specific requirement within that category. Darker blocks indicate higher percentage of partners meeting criteria for each requirement (i.e., a requirement that has been met by 8 of 13 partners will have a lighter tone than a requirement that has been met by all 13 partners. Please note that the requirement to have pediatric screenings included in the Core Comprehensive Standardized Assessment has a denominator of 10, since only 10 of the 13 partners for this project treat pediatric patients. Partner-specific details follow the graph.



Maine Health Access Foundation Site Self-Assessment:

Region 7 IDN has continued the contract with Citizens Health Initiative (CHI) and UNH Institute for Health Policy and Practice (IHPP) to administer a Site Self-Assessment (SSA) Survey to the behavioral health and primary care practices within the region designed to assess their level of behavioral health integration. During this reporting period, Region 7 IDN partners completed the fourth and final follow-up Site Self-Assessment Survey (SSA) to evaluate the region's progress along SAMSHA's integrated healthcare continuum. The survey is based on the Maine Health Access Foundation Site Self-Assessment. To date, practices have completed a baseline survey in June 2017, a follow up survey in December 2017, a second follow up survey in June 2018, a third follow-up survey in June 2019, and a fourth follow-up survey in October 2020. The CHI and IDN7 staff presented the regional results at the November 2020 quarterly meeting, emphasizing the importance of continuous assessment beyond the DSRIP period.

The table below reflects Region 7 IDN progress as of October 2020 in the four specific SSA categories identified as opportunities for improvement in the analysis of the baseline survey results in 2017. As shown below, each category has reflected ongoing improvement in each category with a slight backslide in the June 2019 Follow-up 3 results. This backslide was to be expected as the assessment is a measure of the current state of a practice, dependent on current events impacting the quality of care. Despite this result, Region 7 partners continued to work towards integrated care utilizing the resources available throughout the region.

Maine Health Access Foundation **Site Self-Assessment Categories**	**June 2017 Baseline Results**	**December 2017 Follow-Up Results**	**June 2018 Follow-Up Results**	**June 2019 Follow-Up Results**	**October 2020 Follow-Up Results**
Level of Integration - Primary Care and Mental/Behavioral Health Care	5.8	6.0	6.4	7.4	7.5
Patient/Family Input to Integration Management;	4.9	5.4	6.0	6.3	7.0

Physician, Team and Staff Education and Training for Integrated Care	5.6	6.1	7.3	6.6	7.3
Patient Care Team for Implementing Integrated Care	5.5	6.6	7.0	7.1	7.6

Improvement strategies were discussed at the Region 7 IDN Quarterly meeting on November 19th, 2020 to help partners prepare for assessment beyond the DSRIP period. The team shared QI tools and activities including PDSAs, process mapping, prioritization, data collection. Characteristics for success were also shared, including regularly scheduled meetings, data collection support, leadership support, "teamness." Finally, CHI shared that they continued to remain available to individual practices as a resource for further assessments and technical assistance with quality improvement practices based on assessment results after the demonstration ended.

Partner Specific Updates

As noted in the Project Plan Implementation (PPI) section of this report, many partners in Region 7 have dedicated considerable time and effort during the reporting period working to ensure that their most vulnerable patients and clients remained connected to services. As a result of COVID-related disruptions, not all partners have been able to dedicate time to producing quantitative data that informs this report, or to sharing detailed narrative reports of their work. Reporting gaps remain, so some of the performance target aggregate totals may have decreased over the last two reporting periods. These regressions may reflect staffing losses and reductions or be the result of incomplete data sets.

Ammonoosuc Community Health Services (ACHS)

- Current Status: Integrated Care
- Integrated Care Criteria Met: As reported in prior periods, ACHS has fully implemented all criteria for both coordinated and integrated care practice and maintained that status throughout the current reporting period despite disruption from the COVID pandemic. This includes a fully hardwired process for administering a Core Comprehensive Standardized Assessment (CCSA), routine case consultations by a multidisciplinary core team, use of electronic means to communicate in a timely manner with their partners along the continuum of care, and adoption of standardized workflows and protocols as required under the coordinated care practice designation. This partner also uses evidence-based interventions for both Medication Assisted Treatment (MAT) and the treatment of mild to moderate depression within the primary care setting. Finally, this partner successfully utilizes information available through their health information system to identify at risk patients, plan their care, and monitor patient progress, leveraging relationships with social service organizations in their community to address unmet needs related to the social determinants of health.
- Integrated Care Criteria Unmet: There are currently no unmet criteria for this partner, although they did temporarily suspend their multidisciplinary core team meetings as the clinic pivoted to prepare their response for the COVID pandemic. By the end of the reporting period, however, this practice had resumed, and this partner continues to provide fully integrated care to their patients and clients. As the organization increased the number of telemedicine appointments, members of the Behavioral Health team noted that these visits often allow providers an unprecedented level of visibility of patient homes, which has been game changing in some cases because providers are better able to understand the social determinants impacting their patients' health and wellness. The Director of Behavioral Health notes that staff are now able to

provide the same care remotely that they do in the office but are now able to be reimbursed for that work. She is enthusiastic about the potential to continue offering these services to patients of ACHS.

- Major Accomplishments: Most notable for this partner is their commitment to engaging all disciplines in the delivery and review of care for their most complex patients and those burdened with chronic disease. As previously reported, ACHS has adopted a culture of continuous quality improvement, convening interdisciplinary groups on a regular basis to ensure that whole person care is delivered to patients, including connection to social services that support their health and well-being. The clinic has also successfully integrated a behavioral health provider in a number of local schools, ensuring that children who struggle with behavioral health needs have ready access to behavioral health professionals in ways that are minimally disruptive to their learning. During the reporting period, the ACHS social worker providing services to school children opted to continue delivering services to her school-based clients over the summer break, despite treatment during school holidays not usually being a part of the services ACHS offers. This service was continued because ACHS recognized that the stresses of the pandemic were significantly impacting students who had been through significant disruption at the end of the previous school year.
- Major Barriers/Setbacks to Achieving Integrated Care Status: Although not a barrier or setback, like many partners in this geographically broad region, ACHS has primarily achieved integration by establishing service lines within their own organization rather than partnering with external providers. As relationships across the region have deepened and the health care system has experienced greater stress under the COVID pandemic, ACHS has taken the opportunity to examine their internal processes and the changing landscape of resources in the North Country, delegating some roles and functions to external partners in an effort to streamline their own services to achieve both process and fiscal efficiencies. For example, they have opted not to replace the behavioral health case manager and community health workers who left ACHS at the beginning of the prior reporting period and instead partnered with the Wellness and Recovery Model (WARM) at North Country Health Consortium (NCHC) for the services previously provided by those two internal positions. This has allowed them to invest during this reporting period in the addition of more behavioral health clinicians, including another LICSW who will being providing integrated services to even more schools in the region in 2021. This partner notes that, if telehealth allows them to continue providing high quality care without patients being physically present, they want to continue delivering services through a telemedicine model. This mode of delivery eliminates transportation concerns that are significant for some of their most complex patients, and avoidant and anxious patients are doing better about keeping their appointments. ACHS would like to keep this in their toolbox for both medical and behavioral health services, but this partner is already gearing up for the logistical fights with insurance companies that have begun signaling that telehealth will require prior authorizations.

Coös County Family Health Services (CCFHS)

- Current Status: Both Coordinated and Integrated Care statuses are in progress.
- Integrated Care Criteria Met: CCFHS continues to use the recommended assessment tools for universal screenings and screenings for pediatric patients and builds patient care plans based on the findings of regular assessments for social determinants of health. This partner also leverages electronic means to communicate effectively across the health care continuum,

adhering to guidelines that protect the privacy of their patients and ensuring that information is not shared among care providers without the patient's permission. CCFHS has also implemented evidence-based practices for MAT and the treatment of depression in the primary care setting and leverages technology to identify at risk patients, plan their care, and monitor patient progress towards their goals. Finally, this partner has put steps in place to ensure that there are closed loop referral processes in place with social service organizations.

- Integrated Care Criteria Unmet: Despite having a robust care coordination department and strong connections to community-based organizations throughout the Androscoggin Valley, there are some key components of both coordinated and integrated care practice that this partner has not yet achieved. Notably, CCFHS continues to use a CCSA that does not meet or address all domains required under the coordinated care practice criteria and has not established or joined a multidisciplinary core team whose composition meets the criteria set forth in the coordinated care practice guidelines adopted under the DSRIP. As a result, this partner does not meet coordinated care practice criteria. CCFHS is a practice, though, that has deep and meaningful cross-sector connections in their area. While not the formal Multi-Disciplinary Core Team approach outlined in the Special Terms & Conditions, a compelling argument can be made for the interconnectedness CCFHS has developed with its local partners in order to address complex needs of individuals in their care. Their social worker is receiving regular referrals for intervention and during the reporting period collaboration between the social worker and the shared Care Coordinator resulted in CCFHS taking the lead on forming a community-based workgroup addressing the issue of homelessness in the community. Although they do not have a formal Multi-Disciplinary Core Team, they do have an MAT team that meets weekly with multiple disciplines, including the care manager, to talk about coordinating care for their patients with substance use disorder. During the reporting period, CCFHS also coordinated a regular COVID Response Team call for the Androscoggin Valley that has connected education, business, law enforcement, healthcare, and social service organizations in a collaborative effort to track and respond to trends in COVID transmission and community needs.
- Major Accomplishments: This partner has built strong relationships across both the healthcare and human service sectors in the Androscoggin Valley. They have also continued to share a care coordinator position with Androscoggin Valley Hospital (AVH), which positions them uniquely to understand and plan for care transitions. They partner regularly with the Family Resource Center, the Doorway at AVH, and large prisons in Berlin, NH, to address the needs of their community's most vulnerable patients. This partner has integrated both behavioral health and oral health into their service lines, operating both throughout the pandemic at a time when dental services were virtually unavailable in the region and they were noting an increase in behavioral health crises among patients struggling with the uncertainty and isolation brought about by COVID.
- Major Barriers/Setbacks to Achieving Integrated Care Status: Through multiple discussions with leadership at CCFHS it has become clear that they were unlikely to take the steps necessary to meet these final criteria on the path towards integrated care simply to meet the requirements of this demonstration by significantly altering their existing workflows. As the pandemic has dragged on, the initiative fatigue reported in the previous period has been replaced by a deep investment in processes to provide COVID testing and contact tracing services to the community.

Friendship House/North Country Health Consortium (FH)

- Current Status: Coordinated care status met; Integrated care status in progress.
- Integrated Care Criteria Met: this partner has successfully adopted a CCSA and shared care planning process. Through the adoption of the Region 7 IDN Multidisciplinary Core Team protocols, this partner put in place a process by which their complex patients can be evaluated at monthly case conferences and are using electronic means to ensure timely communication of sensitive information. FH has also adopted all the necessary workflows and protocols required under coordinated care practice, have policies in place to address MAT and the treatment of mild to moderate depression, and are collaborating effectively with social service organizations in a formalized way.
- Integrated Care Criteria Unmet: At this time, the only criteria not yet met on the SAMHSA framework for coordinated and integrated care practice is the use of technology to identify, plan the care of, and monitor progress towards goals for at-risk patients. At the beginning of this reporting period, FH was beginning to investigate the potential of joining the Collective Medical network for the purposes of meeting these requirements. Unfortunately, before a planning meeting could be scheduled with Collective Medical to start the implementation process, the COVID pandemic began and FH was forced to significantly alter their operations in order to respond to the pandemic. At the end of the reporting period, FH withdrew from the IDN as North Country Health Consortium ended the clinical services program.
- Major Accomplishments: Over the course of the demonstration, FH underwent significant improvement in clinical processes. This partner successfully applied for and received accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) in its first attempt at obtaining said accreditation. This work required significant attention to the development of policies and procedures that guide staff in evidence-based practice as they provide residential, intensive outpatient, and outpatient services to patients in need of Substance Use Disorder treatments. In the course of developing these protocols and policies, FH has also worked to build relationships with other partners in the region, ensuring that primary care and social services are available to their residents and clients.
- Major Barriers/Setbacks to Achieving Integrated Care Status: During the reporting period, FH reopened its residential programs in a modified volume that allowed the organization to comply with COVID-19 recommended guidelines. This resulted in a slowdown of progress along the integrated care continuum as leaders and staff focused instead on finding solutions to the facility design and staffing challenges so the residential treatment program could be reopened. FH implemented telehealth processes for their Intensive Outpatient Program and Outpatient clinical services, and dedicated time during this reporting period to establishing formal relationships with social service organizations that could provide support to clients on waitlists. FH successfully reopened its residential programs in June but continued to struggle with low census levels that were financially unsustainable. After careful consideration by the Board and collaboration with the State of New Hampshire Department of Health and Human Services, clinical services were closed at the end of 2020. IDN partner AHEAD, Inc. retained ownership of the Friendship House campus and was in the process of securing a new provider of clinical services to restart programs in the area.

Huggins Hospital

- Current Status: Integrated Care Status met

- Integrated Care Criteria Met: Huggins has met all criteria for integrated care, including full adoption of coordinated care criteria; adoption of evidence-based interventions for MAT and the treatment of mild to moderate depression; and the use of technology to identify at risk patients, plan their care, and monitor their success and progress toward goals. Most notable for this partner during the reporting period was the successful redesign of its care coordination program, taking advantage of slower clinic and hospital volumes to evaluation processes and workflows to better serve their most complex patients.
- Integrated Care Criteria Unmet: This partner does not have any unmet integrated care criteria at this time.
- Major Accomplishments: Huggins continues to be a partner that is dedicated to whole person care and is committed to collaborating closely with other organizations. They are consistent participant in Region 7 IDN activities, including large events like quarterly all-partner meetings and small events like the weekly COVID Touch Base calls that have been occurring in the region since late April. A notable strength throughout the demonstration has been their commitment to a pilot and spread methodology for the adoption of each of the recommended interventions on the continuum of coordinated to integrated care practice. While this practice has resulted in longer implementation windows for some interventions, those implementations have been successful and experienced remarkable buy in from providers and patients as a result of this careful planning and implementation process. During the reporting period, they also implemented a new electronic medical records system, which has allowed them to better capacity to use data analytics to identify and plan care for their sickest patients.
- Major Barriers/Setbacks to Achieving Integrated Care Status: Huggins has shared that, during the COVID pandemic, they experienced a setback in their care coordination department. Shortly before the pandemic began, a long-term member of the care coordination team left the organization, necessitating the hiring and training of a new team member. As a result of their role as a testing facility during the COVID pandemic, staff had less bandwidth for care coordination and case management activities. At the same time, however, patient census in all areas slowed significantly. Huggins took advantage of this decrease in patient volumes to examine its case management processes and redesign their care coordination program. During the COVID pandemic, Huggins has continued to be transparent in engaging social service organizations and other Region 7 IDN partners in care coordination and integrated care processes.

Indian Stream Health Center (ISHC)

- Current Status: Integrated Care status met.
- Integrated Care Criteria Met: At this time, ISHC has continued to maintain adherence to integrated care practices, including full adoption of the CCSA and shared care planning processes, use of a multidisciplinary core team, information sharing by electronic means, and adoption of workflows and protocols required as part of coordinated care status. The agency has adopted evidence-based interventions for MAT and the treatment of depression in the primary care setting and continues to use the Collective Medical platform for coordination of care for at risk patients and collaborate with community-based organizations.
- Integrated Care Criteria Unmet: While there are no integrated care criteria currently unmet by ISHC, they have had significant staffing challenges throughout the COVID pandemic resulting in a decrease in the number of behavioral health providers available within their organization. ISHC continues to refer patients to other organizations that do have capacity to meet the behavioral

health needs of their patient population and collaborate with community-based organizations to address needs related to social determinants of health.

- Major Accomplishments: During the reporting period, ISHC has continued their implementation of a new health information system that will allow them to continue providing integrated health care services to their patients. Over the course of the demonstration, ISHC has successfully implemented an interdisciplinary care team that partners behavioral health providers with primary care providers and nursing staff to regularly review care delivered to the most complex patients they treat. ISCH has conducted a quality review of their process for conducting depression screenings and using results to inform care plans. Through these process improvement efforts, patients who score 15 or greater on the PHQ9 screen, now experience a warm handoff to a behavioral health provider either in person or virtually. The team at ISHC has also reinvigorated a program for conducting reviews on patients who are on high doses of opiates, incorporating behavioral health and a team approach to identify opportunities to decrease doses. Additionally, any patient who receives opiates for more than seven days are required to see a behavioral health provide to ensure that any underlying concerns or conditions are addressed. The medical team has also committed to starting pain management with non-opiate alternatives unless there is a significant medical history of failing those trials. ISHC continues to refer patients eligible for MAT to other providers in the area for those services.
- Major Barriers/Setbacks to Achieving Integrated Care Status: During the reporting period, ISHC has lost several key staff members responsible for monitoring of integrated health care processes. While this has not directly impacted the delivery of care to their patients, it does stress their system and place the sustainability of some integrated healthcare processes at risk. It has also impacted their ability to report on the quality of care delivered to their patients, including participation in reporting outcomes measures for the demonstration. The Region 7 IDN team continues to be in regular contact with ISHC to offer support and assist with collaboration across the region.

Littleton Regional Healthcare (LRH)

- Current Status: Coordinated and integrated care status in progress
- Integrated Care Criteria Met: At this point in time, LRH is successfully using technology to identify at risk patients and plan and monitor their care.
- Integrated Care Criteria Unmet: All other categories of integrated care delivery remain in progress at LRH. While the CCSA has been built into their health information system, and pediatric and universal screenings are occurring regularly, the is not yet widely used by all primary care providers at LRH. This partner was not able to adopt protocols for the use of the regional multidisciplinary core team during this reporting period, and also lost portions of their behavioral health team during the COVID pandemic. Additionally, this agency has not fully implemented a standard of care reflecting the adoption of evidence-based interventions for the treatment of depression in the primary care setting and has not formalized relationships with community-based organizations through the development of documented workflows and joint service protocols.
- Major Accomplishments: During the reporting period, LRH continued the day-to-day operations of the Doorway in Littleton. This has included continuing to strengthen relationships with the WARM team at NCHC and fellow IDN 7 partner North Country Serenity Center for recovery-oriented supports of their clients. In early 2021, the primary care team will be implementing new templates in the electronic medical record (EMR) that will have mandatory fields that will

allow providers to assess all domains over time. As part of their work within an Accountable Care Organization, LRH is using the Athena platform for population health management and has mapped mandatory fields within their EMR to feed to Athena for analysis. This initiative has been on hold during the COVID response of 2020 but is anticipated to go live on February 1, 2021.

- Major Barriers/Setbacks to Achieving Integrated Care Status: LRH has continued to struggle with the hardwiring of processes required under this core competency project. Consistently throughout the demonstration, the primary care practice has lacked adequate staffing to dedicate efforts towards garnering buy-in for process changes and monitoring them for successful implementation. Most recently, the COVID pandemic has resulted in a significant decrease in the size of primary care and behavioral health workforce at LRH with almost 40% of staff furloughed. LRH also reports that their Care Coordinator role has been underutilized during the pandemic as the staff person in that role was repurposed to support providers through staff furloughs. This person still performs limited care coordinator tasks, including a daily review of emergency and inpatient admissions, but is primarily focused on daily operations within the primary care practice. Until staffing in the care coordination department can be increased, the team at LRH is finding it incredibly difficult to address opportunities highlighted in care gap reports.

Memorial Hospital

- Current Status: Integrated care in progress
- Integrated Care Criteria Met: Memorial has met most requirements for both coordinated and integrated care status, including successful use of a multidisciplinary core team, use of electronic means to share information among members of the patient's care circle and adoption of workflows and protocols required under coordinated care practice. Additionally, they have successfully adopted evidence-based interventions for both MAT and the treatment of depression, and use technology to identify at risk patients, plan their care and monitor their progress toward goals. Memorial has successfully established formalized relationships with community-based organizations working to address needs related to social determinants of health, most notably a partnership with recovery community organizations to provide 24/7 recovery supports to individuals with Substance Use Disorder seeking treatment in the Emergency Department.
- Integrated Care Criteria Unmet: The only criteria currently unmet by Memorial Hospital is the use of a CCSA that includes all 10 required domains. Over the course of the reporting period, the capacity of staff at Memorial has largely been consumed by the hospital's duties as a COVID testing facility with little bandwidth for improvement processes. Staff continue to feel confident that providers are regularly querying all areas, but not all domains are easily documented within the health information system and it is therefore difficult to verify that all providers are querying all domains on an annual basis.
- Major Accomplishments: During the demonstration, Memorial has successfully implemented a new health information system that provides them with more robust opportunities to use and share information across multiple disciplines and agencies. Memorial has also successfully led the way on a regional collaboration in the Mount Washington Valley, partnering with Saco River Medical Group, Children Unlimited, and Visiting Nurses Home Health and Hospice of Carroll County, to provide care coordination services to at risk children and families in their region.

- Major Barriers/Setbacks to Achieving Integrated Care Status: The most notable challenge to successful implementation of initiatives recommended under the demonstration has been Memorial's affiliation with its parent organization, MaineHealth. Memorial is the only MaineHealth facility in the state of New Hampshire, but its organizational hierarchy requires authorization from the parent system before implementing large scale projects like connection to the Collective Medical platform or alterations to Health Information System processes. Local leaders are supportive of the initiatives set forth in the Region 7 IDN project and implementation plans but are not always able to realize adoption or implementation of project components if the recommended intervention is not aligned with the strategies and focus areas for MaineHealth.

Northern Human Services (NHS)

- Current Status: Integrated Status met
- Integrated Care Criteria Met: NHS continues to meet all requirements of both coordinated and integrated care practice including the effective use of technology to communicate with partners; identify at risk patients and plan their care; the hardwiring of workflows and protocols as required under the integrated care criteria; and strong collaboration with social service organizations whose work addresses the needs of NHS clients related to social determinants of health.
- Integrated Care Criteria Unmet: There are no criteria currently unmet by this partner in the integrated care status category.
- Major Accomplishments: NHS has successfully opened two integrated health care clinics in the region, one in Berlin and the other in Littleton. These clinics are operating through successful collaboration with local primary care practices who staff clinics that are physically located within the community mental health centers. While the volume of patients receiving primary care services in these clinics is not high, access to primary care in a familiar and comfortable setting has been significant for the patients served by those clinics. During the reporting period, largely due to NHS' shift to telehealth for many of its appointments as COVID case counts rose across the region, these clinics ceased operation. NHS has stated an intent to resume services as soon as it is safe to do so, however, because of the value it brings to NHS clients who would otherwise go without primary care services. Additionally, NHS is a region leader in terms of hosting and mentoring behavioral health students, maintaining internships during the pandemic. NHS also enjoys solid relationship with the social service agencies that help NHS address the social determinants that impact their clients' health.
- Major Barriers/Setbacks to Achieving Integrated Care Status: As shared in prior reporting periods, one of the most significant barriers experienced by this Community Mental Health Center (CMHC) is the recruitment and retention of experienced workforce members. CMHC's are attractive to new professionals because the clinics have the ability to mentor and supervise emerging behavioral health professionals as they work towards full licensure or certification in their fields. The reimbursement model under which CMHCs in the state of New Hampshire operates, however, makes it difficult for these agencies to offer competitive salaries. As a result, there is regular turnover of staff as newly licensed and certified professionals seek similar work with higher pay at other agencies within the region.

Rowe Health Center/Cottage Hospital

- Current Status: Integrated Care in progress

- Integrated Care Criteria Met: Rowe Health Center has currently met all coordinated care practice requirements including full adoption of a CCSA and shared care plan, multidisciplinary core team, information sharing, and workflows and protocols required under coordinated care practice criteria. In addition, they have also fully adopted the recommended evidence-based interventions of MAT and treatment of mild to moderate depression in the primary care setting. The recent conversion to a new health information system has enhanced their ability to use technology to identify the needs of at-risk patients and appropriately plan and monitor their care. Finally, this partner documented workflows for collaboration with social support community-based organizations.
- Integrated Care Criteria Unmet: At this time, only two criteria for integrated care practice remain unmet. The first is the adoption of joint service protocols with community-based organizations to complement their stated workflows for referring patients to these services, and the second is the use of communication channels including closed loop referral capabilities when working with community-based organizations. In previous reporting periods, this partner experienced staffing changes that slowed some of their progress on these requirements. Rowe remains interested in continuing to formalize and codify the processes that are currently in use.
- Major Accomplishments: As this partner contemplated the adoption of MAT protocols, it became clear that adding this particular service line to their existing provider base would not be feasible. Rather than leaving their substance use disorder affected patients without access to MAT, they located another practice in their community that had MAT waivered providers with capacity to receive additional referrals. In building this relationship, Rowe has ensured that their patients' needs are met without exposing the clinic to potential financial difficulties by implementing a service line they could not support. This type of cross agency collaboration benefits both patients and providers. Additionally, Rowe has successfully embedded psychiatric nurse practitioners in their adult internal medicine practice, and then partnered with a local psychiatrist for the necessary oversight to ensure that their nurse practitioners are well supported and that they meet the guidelines set forth under the DSRIP. This model of collegial support allows the nurse practitioners to continue to be independent practitioners as outlined in New Hampshire statute, without burdening the organization with the expense of recruiting and employing a full-time psychiatrist. This model has allowed for the practice to develop the habit of holding weekly meetings between behavioral health and internal medicine providers, where cases brought forward by medical providers have collaborative care plans developed that reduce heavy utilization of the emergency department and increase use of services such as chronic disease self-management programs. Rowe has moved some of these offerings to telemedicine platforms during the pandemic in order to continue to engage patients safely in these efforts.
- Major Barriers/Setbacks to Achieving Integrated Care Status: Cottage Hospital/Rowe Health Center continues to express concern that care coordination services are poorly reimbursed under existing payment models. This makes it difficult for them to deepen their care coordination bench. Regardless of this challenge, they have initiated a relationship with the community health worker program at NCHC to provide additional case management and integrated health care services to their most at-risk patients.

Saco River Medical Group (SRMG)

- Current Status: Integrated Care in progress

- Integrated Care Criteria Met: SRMG has met most requirements for integrated health care, including the adoption of evidence-based interventions for MAT and the treatment of depression, the use of technology to identify at risk patients, plan their care, and monitor progress on those care plan goals, and collaboration with social support organizations.
- Integrated Care Criteria Unmet: Despite having adopted all required integrated health care practices, this partner has not yet met integrated care status because they have not fully implemented two key processes under the coordinated care criteria. During the reporting period, SRMG adopted the region's protocols for the use of the Region 7 multi-disciplinary core team, but that team has not been convened due to a lack of submitted cases. SRMG is hoping to build a relationship with NHS for monthly consultation of a psychiatrist in the coming year.
- Major Accomplishments: SRMG has successfully entered into a collaborative care agreement with Mount Washington Valley Supports Recovery (MWVSR), providing necessary primary care services to MWVSR clients and referring SRMG patients to this RCO for recovery supports. SRMG has also been a longtime participant in the Memorial Collaborative, which provides care coordination services to at risk youth and families in the Mount Washington Valley.
- Major Barriers/Setbacks to Achieving Integrated Care Status: SRMG continues to be an engaged partner in the region, but as with other practices in the area, staff bandwidth and access to a psychiatrist continue to be barriers to full adoption of a multidisciplinary core team.

Weeks Medical Center (WMC)

- Current Status: Integrated care status met.
- Integrated Care Criteria Met: WMC has maintained all requirements for integrated care status for several reporting periods. At this time, a culture of integrated healthcare delivery has been hard wired with this partner, and they continue to deepen the relationships between physical and behavioral health providers both within their organization and with other organizations across the region.
- Integrated Care Criteria Unmet: At this time, this partner has no unmet requirements for the delivery of integrated healthcare.
- Major Accomplishments: WMC has been dedicated to the implementation of integrated healthcare processes and enhanced care coordination for several years now. Their largest contribution to the regional adoption of integrated healthcare was the implementation of the North Country Recovery Center. This is a substance use disorder treatment program embedded in the primary care practices of WMC, which has been partially funding by Region 7 IDN. As a result of the extensive work done by WMC to hire the necessary workforce and establish standards of care and protocols and procedures for the program, the North Country was well positioned to offer clinical services at the two Doorway locations in northern Grafton and Coös County. At the start of the statewide Doorway initiative, they were the only two Doorway locations in the state that offered clinical services on site. No update was available from this partner for the current reporting period, largely due to the significant work underway at the facility to implement a new electronic medical record system and serve as one of the state's COVID testing centers.
- Major Barriers/Setbacks to Achieving Integrated Care Status: as noted with other Region 7 IDN partners, WMC has achieved integrated care status primarily through the expansion of its primary care practice, adding additional clinical services to an already robust primary care setting. While this has certainly achieved the delivery of integrated health care for patients in their catchment area, these services are primarily available only to patients of WMC.

White Horse Recovery and Behavioral Health Services (WHR)

- Current Status: Integrated care status met.
- Integrated Care Criteria Met: WHR has fully implemented a CCSA, adopted protocols to leverage the regional multidisciplinary core team, and adopted all required workflows and protocols to meet all criteria for coordinated care practice. It has also implemented evidence-based interventions for MAT and established a process by which technology is used to identify at risk patients, plan their care and monitor patient progress towards their goals. This has largely been achieved through the implementation of a health information system which started in the fall of 2019 and was completed in the early months of the current reporting period. WHR has also successfully documented workflows and joint service protocols for their collaboration with other social support organizations in Carroll County. During the most recent reporting period, WHR has begun using the newly implemented electronic medical record to exchange information electronically with its regional partners and have adopted treatment protocols for the treatment of mild to moderate depression.
- Integrated Care Criteria Unmet: At this time, this partner has no unmet requirements for the delivery of integrated healthcare.
- Major Accomplishments: WHR has made significant strides over the course of the demonstration. They began as a relatively small organization with limited sustainability but have leveraged their connectivity to the IDN and funding through incentive payments to create and implement a sustainability plan that has positioned them to serve the region well for many years to come. This has included the introduction of behavioral health services to their recovery organization, which has allowed them to enroll as a participating provider in a number of commercial and government payer programs. As of December 2020, they now employ eight clinicians delivering these services, and partner with MAT prescribers in Carroll County to delivery integrated services to their clients. During the reporting period, work continued to build a larger facility that can accommodate residential services and provide additional space for outpatient services delivered through the recovery programs. While not yet complete, WHR was able to open a larger thrift shop and shipping center during the reporting period that has allowed for additional income to fund programs and has fully leaned into the North Country Trainer's Collaborative, working to increase the knowledge and capacity of the recovery workforce in Carroll County. Finally, WHR has spearheaded efforts to develop and implement a team of recovery support volunteers who can respond to patients in need at local emergency departments in Carroll County. This work has been largely successful due to WHR's strong collaboration with fellow Recovery Community Organization and IDN7 partner Mount Washington Valley Supports Recovery. During the current reporting period these partners have successfully these services to Huggins Hospital in southern Carroll County. During this reporting period, WHR has hired a new Clinical Director who is an LICSW and has dedicated time to rewriting clinical protocols to better align with the SAMHSA continuum of coordinated and integrated care.
- Major Barriers/Setbacks to Achieving Integrated Care Status: A primary challenge for WHR throughout the demonstration has been the lack of an electronic record system that can facilitate the collection of CCSA data, transmit information to other care providers involved in clients care, and be used to identify at risk patients in order to provide them with integrated care. WHR has made significant strides in the last year as they have completed the implementation of an electronic medical record system and engaged with Collective Medical to help overcome this barrier. Additionally, they have worked diligently during the reporting

period to adopt all of the required policies and protocols outlined in this project. At this time, their primary barrier to the delivery of integrated care continues to be the lack of affordable housing for members of their integrated health care workforce. It is necessary to have a reliable inventory of affordable housing for professionals because there are not an adequate numbers of behavioral health professionals currently living in the region, so when new hires are made those professionals are relocating and need a place to live. As reported in the previous period, Carroll County's already significant shortage of housing inventory has been made worse through the COVID pandemic. Additionally, they note that there has been some pushback from County officials regarding their entry into the behavioral health field. This reflects the lack of broader understanding across community that substance use disorder has its roots in mental health needs, and WHR has committed to continuing to advocate for mental health services for their clients, believing that addressing the root causes of substance misuse is essential to helping individuals maintain their recovery long term.

White Mountain Community Health Center (WMCHC)

- Current Status: Integrated care met.
- Integrated Care Criteria Met: As is the case with Weeks Medical Center, WMCHC has maintained integrated health care status for several reporting periods. All criteria are met, and this partner now regularly engages in continuous quality improvement processes aimed at further refining adopted protocols and workflows to continue enhancing their delivery of integrated health care.
- Integrated Care Criteria Unmet: At this time, no criteria for integrated care remain unmet although this partner noted that during the COVID pandemic some of their processes changed to accommodate their shift to telehealth services. For example, the CCSA is typically administered in a paper format and it was not possible to continue that process in the virtual visit environment. While the paper forms may not have been used, the queries around social determinants of health continued to be made as providers connected directly with their patients through video conferencing and telephone calls rather than receiving data from the CCSA through their clinical support staff. Both providers and patients have expressed increased satisfaction with this process. As is their habit, WMCHC is now evaluating altered processes implemented during the pandemic to determine which should be hardwired moving forward. During the most recent reporting period, WMCHC began using an IDN funded Health Information Technology system, UpDox, to send electronic questionnaires to their patients in order to collect vital information, including queries related to social determinants of health and COVID screenings.
- Major Accomplishments: WMCHC is an excellent example of an integrated health care partner who has leveraged technology to improve the integration of the services that they offer and have leverage the information on the Collective Medical network not only to improve the quality of care provided to individual patients, but to improve overall service delivery at the organizational level. They have also consistently partnered with other organizations to ensure that social needs of their patients are met. The most recent example of this partnership is WMCHC's entry into a collaborative care agreement with MWVSR, sharing referrals from MWVSR to WMCHC for primary care services, and in the reverse for recovery support services, for their shared patients/clients. WMCHC is also a supporter of workforce development, often serving as an experiential learning site for behavioral and medical health interns and supporting the professional development of its existing staff.

- Major Barriers/Setbacks to Achieving Integrated Care Status: A primary barrier to continued success for WMCHC is that their pathway to becoming a Federally Qualified Healthcare Center (FQHC) has not yet been realized. WMCHC currently has status as an FQHC Look Alike practice, and they have adopted all of the processes and patient centered medical home philosophies required of FQHCs but have not yet been successful in receiving FQHC status. As a result, they lack access to the federal grants that support the innovation of FQHCs around the country. As previously reported, this inequity was felt strongly during the COVID pandemic when the CARES act was written to provide relief to FQHCs but remained silent on support for FQHC Look Alike practices such as WMCHC.

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting. In your narrative please also speak to any variances from your proposed cost to your actual spending.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	01/01/2019-12/31/2019	1/1/2020 - 6/30/2020	7/1/2020 - 12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
Core Competency	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June ACTUAL	CY 2020 July to Dec ACTUAL	CY 2020 ACTUAL	CY 2021 Projected
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants									
5. Supplies:									
Educational									
Office	$4,650	$707	$558	$456	$1,014	$351	$96	$447	$182
6. Travel	$3,560	$3,159	$972	$972	$1,945	$211	$452	$662	$452
7. Occupancy									
8. Current Expenses									
Telephone									
Postage									
Subscriptions									
Audit and Legal									
Insurance									
Board Expenses									
9. Software		$2,127	$1,144	$1,855	$2,999	$646	$543	$1,190	$455
10. Marketing/Communications	$5,218	$12,986	$860	$923	$1,784	$82	$4	$86	$42
11. Staff Education and Training		$5,335	$1,307	$1,307	$2,615	$905	$317	$1,220	$317
12. Subcontracts/Agreements									
13. Other (specific detail mandatory):									
Current Expenses: Administrative Lead Organizational Support	$7,851	$6,503	$1,415	$1,321	$2,735	$761	$439	$1,201	$421
Support Payments to Partners	$315,939	$498,402	$128,340	$198,969	$327,309	$43,472	$82,597	$126,068	$469,266
TOTAL	$ 444,143	$ 677,601	$ 243,801	$ 296,956	$ 540,758	$ 118,348	$ 142,311	$ 260,660	$ 508,254

At the beginning of the demonstration, Region 7 opted to take the approach of budgeting based on how incentive payments are earned. This approach has been used for staffing as well as partner requests for funds and was adopted because partner proposals and staff time often touch multiple DSRIP projects concurrently. Expenses have therefore been allocated as a flat percentage across project areas, with the region setting out initially to roughly budget the funding across projects in parallel to the proportions in which the incentive payments were earned.

As funding uncertainties mounted in 2018 and 2019, the region maintained the original allocation rather than making the shift in the weighting from the state-wide projects to the core competency project. This has resulted in allocations of approximately 42% of funding to state projects, 36% to the core competency project and 22% to community projects for the life of the DSRIP. Proposed expenses for the remainder of the demonstration include anticipated costs for infrastructure staffing, subscription to the Collective Medical Network and distribution of remaining earned incentive payments to partner

organizations in support of their ongoing work to meet the goals of the DSRIP. Variances experienced to date include:

- Reductions in incentive payments available following decreased county contributions for years 3 and 4.
- Failure of the region to meet 100% of incentive payment targets for both process and performance measures.
- The restructuring of infrastructure staffing in line with decreased funding earned by the region, the rationale being that if there was less money available for partner organizations, the infrastructure team should be similarly reduced.

B1-10. IDN Integrated Healthcare Project: Achievement of Coordinated Care Practice and Integrated Care Practice Designation

Use the format below to identify the total number of practices/providers who have **achieved** designation as a Coordinated Care Practice or Integrated Care Practice. IDNs are expected to make continual progress toward achieving their projected number of designated Coordinated Care Practices and Integrated Care Practices.

Achieved	Total Goal Number Designated	Baseline Designated 12/31/18	Number Designated 6/30/19	Number Designated 12/31/19	Number Designated 6/30/20	Number Designated 12/31/20
Coordinated Care Practice	13	7	6	7	7	10
Integrated Care Practice	9	0	5	5	6	7

Projects C: Care Transitions-Focused

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

Network Membership

During the reporting period of July 1 through December 31, 2020, one partner, NCHC Clinical Services/Friendship House, left the network, bringing the total number of partners in the Region 7 IDN to thirty-eight (38). The information below speaks to the progress that Region 7 IDN has made on the C1 "Care Transitions" Community Project during this reporting period.

Key organizational and provider participants

Organization/Provider	Agreement Executed (Y/N)
Carroll County Department of Corrections	Y
Family Resource Center at Gorham	Y
Tri- County Community Action Program	Y

Regional Progress

Region 7 IDN partners selected project C1: Care Transition Teams to increase needed support critical to individuals with serious mental illness as they transition from the hospital setting back into the community. As noted in the original project plan, Region 7 IDN partners selected Care Transition Teams as a community-driven project after consideration of the feasibility of implementing the Critical Time Intervention model. IDN participants agreed that the model would increase capacity and enhance care transition planning currently in place. Participants identified several areas that could be addressed through this project, including such things as:

- Recidivism that occurs and significantly burdens local capacity.
- Education for patients and families about the unique needs of transitioning back into the community; and
- Effective discharge planning that includes effective feedback and follow-up.

The Region 7 IDN implementation plan established an aim for the region to work together with four other IDNs across the state to implement the Critical Time Intervention (CTI) model. The intent of this initiative was to prevent homelessness and other adverse outcomes in people with mental illness following discharge from hospitals, shelters, prisons, and other institutions. Interestingly, despite the rationale for selecting this community-driven project being so heavily based on the utilization of clinical resources, none of the Region 7 IDN partner organizations who ultimately adopted the CTI model and have continued using it throughout the demonstration period are providers of physical or behavioral health services. Instead, they are social service teams whose case management work has enhanced the clinical services infrastructure by collaborating with and facilitating their clients' journeys across the continuum of care.

Throughout the current and previous reporting periods, these teams have proven invaluable to assuring that the most vulnerable community members in the region remained well connected to those supports

that prevented and/or mitigated housing and food insecurity, addressed concerns regarding domestic and child abuse, and received case management services during incarceration.

During the reporting period, the IDN7 Team continued to serve as the state point of contact for the contract with the Center for the Advancement of Critical Time Intervention (CACTI), coordinating the final two CTI Community of Practice meetings for the demonstration. These meetings were held virtually on August 7 and November 6, and both were facilitated by CACTI expert Kimberly Livingstone, PhD. Discussion at both meetings centered around the challenges of working within the uncertainty of the pandemic and plans for sustainability post-DSRIP.

CTI teams from around the state acknowledged that the isolation and vulnerability experienced by their clients often created enough of an altered situation that the clients were returned to pre-CTI or phase 1 of CTI in order to afford them more intensive supports. Collectively, the Community of Practice agreed that this was a reasonable application of the model, and were appreciative of assistance in navigating a regression, rather than progression, of phases.

Many teams, including those in Region 7, dedicated significant effort during the reporting period to modifying their operational plans in order to continue delivering the CTI model with integrity beyond the DSRIP without the ongoing financial support of the waiver funds. For some, this meant adapting workflows or obtaining billable certifications in order to fit payer requirements for reimbursable case management services. For others, the IDN teams were not in a position to bill payers for their services, so were seeking new homes for their teams with agencies that did have mechanisms for reimbursement. The approaches of the IDN7 CTI teams are outlined within the partner specific updates below.

Partner specific updates

Carroll County Department of Corrections (CCDoC)

During the reporting period, both the Superintendent and clinician serving as the CTI Supervisor for the CCDoC re-entry program left the organization to pursue other employment opportunities. Multiple attempts to reach new staff within the re-entry program at the house of corrections have proven unsuccessful, so few updates on their program are available at the time of this report. Through the reports of other Region 7 IDN partners, it appears that the department's re-entry program continues, but may have moved away from the CTI model due to a loss of CTI trained staff. Continuation of the CTI model has always been challenging for the Department, largely due to the limited ability to work with their clients in community after release from incarceration. No additional updates have become available during the review period.

Family Resource Center (FRC)

FRC continues to deliver supports to parents and families who are under interventions from the Division of Children, Youth and Families (DCYF) and at risk of permanent separation, largely due to issues arising from substance use disorders. The Parent Partners working with families in FRC's Strengths to Succeed program use the CTI model to help families transition from a state of being poorly connected to supports and services to being well connected, resulting in family reunification and the bolstering of protective factors that leave these families at less risk of future DCYF interventions. FRC reports that their regularly scheduled CTI supervision meetings continue to be facilitated by an MLADC and credit their ability to deliver the model to fidelity to this consistent team meeting approach.

During the reporting period, FRC has been approached by DCYF to begin working with families further upstream, primarily those families for whom intake reports of potential abuse and/or neglect have been received but have not risen to the level of formal action on the part of the Department. Leadership at FRC believe that CTI will be the primary model used with these new clients regardless of their DCYF involvement, given the significant prevalence of SUD/OUD in the community and the efficacy of the model in helping these clients successfully enter and maintain recovery and stronger family relationships.

FRC notes that their CTI workers are seeing a significant increase in the need for housing among the clients served, with housing insecurity proving to be a significant barrier to success for the clients. During the reporting period, FRC has also opened up the scope of services to include supports to clients struggling with mental health needs as well as substance use disorders. This has resulted in an almost doubling of the number of individuals served in 2020 over 2019. FRC notes that their colleagues at DCYF asked FRC to take on this service expansion because they have been taking note of the increase in mental health needs, have seen the success of the program in working with the SUD-involved families and acknowledge that these conditions are often co-occurring.

As reported by other Region 7 IDN partners during this reporting period, FRC has seen an increase in the number of clients who are struggling with alcohol use disorder as well as the use of methamphetamines, noting that the prevalence of opioid use seems to be decreasing. Staff at FRC have stated that when it comes to illegal substances, they are seeing what appears to be a market influence. In the significant push to get opioids off the streets over the last few years, a vacuum has been left that is being filled by other substances. They have shared that alcohol is legal to obtain and use, so is more easily accessible at the moment, but its misuse is causing a number of big incidents happening withing families that are rooted in the stresses of COVID, remote learning, and financial pressures. This includes an increase in program referrals related to domestic violence incidents and overdoses.

FRC hopes to continue with the CTI program well into the future but shares that this will depend more heavily on a different funding mix. Throughout the reporting period, the agency has focused on becoming established as a Medicaid provider. In terms of services being provided in the region, Strengths to Succeed has opened the door for the opportunity to expand into other areas like the cooccurring conditions and upstream work that has been introduced by DCYF. The team feels strongly that they can have a positive impact by being the front line for folks struggling with mental health needs as a critical first in the door type intervention that kicks off access to the broader services their clients need. FRC hopes that the team will continue to grow and serve more people, noting that SUD and mental health needs aren't going away, as evidenced by the increase in referrals to and DCYF-involved families engaging with FRC's programming, as well as the emergence of self-referrals coming from the community at large. During the reporting period, FRC has become licensed as a recovery support peer organization, giving the agency the ability to be reimbursed for their services. FRC looks forward to completing Medicaid enrollment so that they can offer their services to people outside the grant funded DCYF work as well.

Tri-County Community Action Program (TCCAP)

TCCAP reports that they have doubled the Critical Time Intervention (CTI) workforce during this reporting period by splitting each CTI position into a Case Manager position and an Outreach Coordinator for each of the counties. This reshaping of the Homelessness Intervention & Prevention team has allowed TCCAP to move a direct support worker from the region's only homeless shelter, The Tyler Blain House, to an Outreach Coordinator position in Coös in July, a Case Manager for Carroll in

August and both a Case Manager and an Outreach Coordinator Northern Grafton in September & October.

This new staffing model has allowed staff to focus in on one aspect of supporting folks with restabilizing their housing. The Outreach Coordinator works with individuals through the point of transitioning from pre-CTI to CTI phase one, which includes obtaining housing and moving in. At this point in the process, the Outreach Coordinator then provides the client with a warm handoff to the Case Manager who continues providing phased out case management services consistent with the CTI model. TCCAP notes that this has been a notable change for staff satisfaction as well, stating, "This has allowed us to help staff do the work that they're most passionate about – not every person wants to be counting people in the woods and finding furniture." In addition to regular paid staff, TCCAP notes that they have had a wonderful volunteer response to their calls for a Point in Time (PIT) count of housing insecure individuals in January. This is in contrast to what they hear from similar organizations around the state who are struggling to find volunteers for this important needs assessment.

As anticipated, TCCAP's client intake into their CTI program has slowed down during the reporting period, partly due to fresh staff who have smaller caseloads and partly due to the focus the organization needed to put on the housing relief program to prevent the emergency of hundreds facing homelessness due to the financial impacts of the pandemic. TCCAP notes that staff worked with many people through housing relief program that generally were not the population they would typically serve had COVID not been in the mix. The COVID-related work required staff to split their attention, performing triage of cases to identify which services were needed, slowing down enrollment of new clients into CTI. TCCAP notes that they also have more people than usual in temporary housing situations at hotels and in shelter, because finding housing has been a challenge during the pandemic, especially in Carroll County. Family and friends may not be comfortable allowing housing insecure individuals to stay in their homes, so are sometimes offering the use of RVs or caravans or allowing individuals to put some sort of temporary shelter on their land instead.

Staff have been performing a higher than usual number of food and supply deliveries to individuals temporarily housed in hotels. These temporary living arrangements have highlighted the complexity of ensuring that clients have items such as dishes and flatware in order to eat their meals but making sure that the tools and food provided to them are manageable in hotel rooms that may or may not have microwaves and typically have small sinks that are not conducive to dishwashing due to the size and shape of these sinks. Staff report a high awareness of the fact that people may not be self-identifying as homeless or housing insecure because they have some sort of shelter, when in reality they may be in an RV with no running water, have been displaced and are couch surfing with friends, or have moved into their parents' home and are sharing a single room with their children. The shift in language from "Homelessness" to housing security or housing instability is helping to circumvent the stigma, and TCCAP reports having some success throughout the pandemic by naming the situations (i.e., "staying on a friend or family members couch," "not having a lease of your own" etc.) to help potential clients identify that they may qualify for services.

TCCAP reports that the impact of COVID is presenting most frequently with those individuals who were struggling living paycheck to paycheck before the pandemic and now lack the minimum needed to remain stable. Not knowing how secure employment and the income it brings is has been exceedingly difficult as individuals have lost working hours due to the cutbacks made by their employers, resulting in an exacerbation of the conditions that make them vulnerable. TCCAP staff note that mental health needs have been a major issue during this reporting period as prolonged isolation is wearing on clients

and triggering exacerbation of their conditions. Anything that was already hard or had them on an edge has been pushed over the edge by COVID, which makes reaching out for services more difficult. TCCAP sees that societal pressure around emerging norms related to COVID interventions like mask wearing and avoiding non-essential interactions with others has led to more isolation for some clients, decreasing their capacity to make and act upon good decisions regarding their finances and relationships with property owners and utility companies. TCCAP staff have noted an increase in the number of clients who are experiencing depression and then avoiding responsibilities. Property owners are very frustrated right now by tenants who have gotten months behind in their rent, and TCCAP staff want to help by are challenged by property owners who are also struggling financially and do not see the cause behind the late rent as being a valid or legitimate reason for a client to be in arrears.

Despite these challenges, leadership at TCCAP report that their CTI-trained staff are continuing to do an excellent job using the model to assist their clients and moving the funding available through housing relief programs to keep people housed during the pandemic. Some staff are making an even bigger push to have conversations with property owners, make sure clients are sticking to budgets, and providing some limited case management to all clients because they don't have a program to fall back on right now. The team is focusing on the use of CTI Case Management to help individuals maintain their housing because it's so hard to find it in the first place. This includes helping clients negotiate lower rents, use aggressive budgeting to maximize the use of every penny the client has and connecting clients to other resources like food supports so that they can use their own limited finances to pay rent. CTI workers at TCCAP find that the CTI model is allowing them to personalize services to client capacity and needs, which has become even more important as the pandemic has continued. In addition to services to their own clients, TCCAP maintains a CTI Supervisor who is also a CTI trainer that is willing to provide training to other teams in the region who are interested in using this model.

Project Targets

From the Evaluation Project Plan, use the format below to provide a list of the progress toward targets or goals that the program has achieved. Targets required by the STCs, include but should not be limited to:

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

Performance Measure Name	Target (by 12/31/18)	Progress Toward Target				
		12/31/18	6/30/19	12/31/19	6/30/2020	12/31/20
# of individuals served by CTI	120	196	344	482	636	697
# of partner organizations implementing CTI	3	3	3	3	3	3
# of CTI workers positioned in Region 7 IDN	15	37	37	36	40	39

As noted in the Project Plan Implementation (PPI) section of this report, many partners in Region 7 have dedicated considerable time and effort during the reporting period working to ensure that their most vulnerable patients and clients remained connected to services. As a result of COVID-related disruptions, not all partners have been able to dedicate time to producing quantitative data that informs this report, or to sharing detailed narrative reports of their work. Reporting gaps remain, so some of the performance target aggregate totals may have decreased over the last two reporting periods. These regressions may reflect staffing losses and reductions or be the result of incomplete data sets.

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting. In your narrative please also speak to any variances from your proposed cost to your actual spending.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	1/1/2019 - 12/31/2019	1/1/2020 - 6/30/2020	7/1/2020 - 12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
Care Trans	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June ACTUAL	CY 2020 July to Dec ACTUAL	CY 2020 ACTUAL	CY 2021 Projected
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants									
5. Supplies:									
Educational									
Office	$968	147	$116	$95	$211	$73	$20	94	$38
6. Travel		368	$202	$202	$405	$44	$94	137	$94
7. Occupancy									
8. Current Expenses									
Telephone									
Postage									
Subscriptions									
Audit and Legal									
Insurance									
Board Expenses									
9. Software		443	$238	$386	$624	$134	$113	247	$95
10. Marketing/Communications	$1,086	2,369	$179	$192	$371	$17	$1	19	$9
11. Staff Education and Training		522	$272	$272	$544	$188	$66	254	$66
12. Subcontracts/Agreements									
13. Other (specific details mandatory):									
Current Expenses: Administrative Lead Organizational Support	$1,634	2,236	$294	$275	$569	$158	$91	251	$88
Support Payments to Partners	$65,766	103,325	$26,708	$41,407	$68,115	$9,047	$17,189	26,236	$97,657
TOTAL	$ 91,231	$140,409	$ 50,737	$ 61,798	$ 112,535	$ 24,629	$ 29,616	$ 54,247	$ 105,771

At the beginning of the demonstration, Region 7 opted to take the approach of budgeting based on how incentive payments are earned. This approach has been used for staffing as well as partner requests for funds and was adopted because partner proposals and staff time often touch multiple DSRIP projects concurrently. Expenses have therefore been allocated as a flat percentage across project areas, with the region setting out initially to roughly budget the funding across projects in parallel to the proportions in which the incentive payments were earned.

As funding uncertainties mounted in 2018 and 2019, the region maintained the original allocation rather than making the shift in the weighting from the state-wide projects to the core competency project. This has resulted in allocations of approximately 42% of funding to state projects, 36% to the core competency project and 22% to community projects for the life of the DSRIP. Proposed expenses for the remainder of the demonstration include anticipated costs for infrastructure staffing, subscription to the Collective Medical Network and distribution of remaining earned incentive payments to partner organizations in support of their ongoing work to meet the goals of the DSRIP. Variances experienced to date include:

- Reductions in incentive payments available following decreased county contributions for years 3 and 4.
- Failure of the region to meet 100% of incentive payment targets for both process and performance measures.
- The restructuring of infrastructure staffing in line with decreased funding earned by the region, the rationale being that if there was less money available for partner organizations, the infrastructure team should be similarly reduced.

Projects D: Capacity Building Focused

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

Network Membership

During the reporting period of July 1 through December 31, 2020, one partner, NCHC Clinical Services/Friendship House, left the network, bringing the total number of partners in the Region 7 IDN to thirty-eight (38). The information below speaks to the progress that Region 7 IDN has made on the D3 "Expansion in Intensive Substance Use Disorder (SUD) Treatment Options" community project during this reporting period.

Key organizational and provider participants

Organization/Provider	Agreement Executed (Y/N)
Ammonoosuc Community Health Services	Y
Coös County Department of Corrections	Y
Coös County Family Health Services	Y
Friendship House	Y
Hope for NH Recovery	Y
Huggins Hospital	Y
Memorial Hospital	Y
Mount Washington Valley Supports Recovery	Y
North Country Serenity Center	Y
Northern Human Services	Y
Weeks Medical Center	Y
White Horse Addiction Center	Y
White Mountain Community Health Center	Y

Region 7 IDN Partner Specific Updates

Partner specific updates in this section reflect narrative regarding their progress along the continuum of the project, and their total number of unique individuals served during the DSRIP period through December 31, 2020.

Ammonoosuc Community Health Services (ACHS)

ACHS continued to provide Medication Assisted Treatment (MAT) to patients in need during the reporting period, adding new MAT prescribers during the reporting period. The partner has also continued their positive working relationship with the Littleton Doorway by building a referral process into Centricity, their electronic health record platform, to ease care coordination. With the closure of the North Country Health Consortium's clinical services programs at the Friendship House, ACHS has pivoted to offer their services to the incoming programs as they implement new substance use disorder services in the region. This includes building out referral networks and streamlining processes.

ACHS continues to improve coordination between their primary care and behavioral health (BH) team to best serve the patients in need of BH services, despite the elimination of the behavioral health case manager earlier this year. Due to the scarcity of BH providers and the BH case manager duties being absorbed by other ACHS Behavioral Health staff, the Primary Care Providers (PCPs) continue to serve as the front line in treating these patients for general BH concerns. This has impacted the relationship with

North Country Serenity Center (NCSC) established in previous reporting period for ACHS to provide services and mutual referrals for common clients. Although the NCSC team has continued to be successful in getting clients established with Ammonoosuc Community Health Services, they report experiencing longer wait times. ACHS continues to leverage NCHC's WARM program to provide patients with more resources and wrap around services during their recovery instead of maintaining similar services within their own walls.

The teams at ACHS have also developed a simple workflow for referring patients between internal ACHS teams and collaborating to determine an appropriate care plan. The internal referral process has been working efficiently and information sharing has improved providers' ability to coordinate care to best treat the patient. The partner will continue to adjust internal processes to position them to strengthen relationships moving forward.

Coös County Department of Corrections (Coös)

During this reporting period, Coös County Department of Corrections continued their contract with Northern Human Services (NHS) to support the Case Management and Medication Assisted Treatment (MAT) programs launched back in January. The programs continue referring incarcerated individuals with a known release date to a case manager employed by NHS. The COVID-19 pandemic remains a burden on the case management however the equipment set up to support virtual services has been a huge asset for the partner. The use of video conferencing during this time has greatly aided in the provision of services for inmates.

Coös spent the reporting period strengthening relationships with partners across the region resulting in a successful collaboration to provide inmates with the services they need. As a result of these efforts, the case manager at Coös collaborated with a Community Health Worker/Recovery Coach from NCHC'S WARM program to help them contact a Homeless Outreach Specialist at TCCAP. Progress on both reentry initiatives continues to be monitored. Coös reports that one of the biggest challenges in 2020 has been the suspension of court activity. Census at the jail was higher in 2020 than 2019, with a higher portion of pretrial offenders without a known release date. Staff notes that it is difficult to initiate a case management plan without knowing what an offender's sentence length or release date will be, a significant dynamic that made case management extremely difficult to execute with most of the offenders at the facility this year.

As the reporting period progressed, Coös did see an emerging trend of pretrial sentencing, with some of the offenders receiving sentences at the facility. This has provided a level of visibility over where the individuals will be for the near future, allowing for limited interventions to occur during the pretrial phase. Coös has expressed an interest in navigating this tricky phase, when they could potentially provide life-changing services like virtual behavioral health, medicine, medicine, counseling, and the initiation of MAT, but the lack of clarity on how long offenders will be at the facility complicates long term planning. During the reporting period, the team at Coös began to explore the possibility of starting additional counseling services for incarcerated individuals as an opportunity for a little self-discovery that primes them to be more open to case management services and the connections, they provide to community resources post-release when sentencing does occur. Staff feel like there is an opportunity to be a little more assertive with the approach, given that the population is typically 20–25-year-old men with socio-economic and SUD factors that could benefit from these interventions.

Coös County Family Health Services (CCFHS)

At the beginning of the reporting period, CCFHS continue to provide MAT services and host group sessions at their Pleasant Street office so that patients had access to their primary care providers at the same time. These services were somewhat disrupted during the COVID pandemic. While patients continued to have access to their MAT prescribers, groups were suspended temporarily while a location could be identified that permitted gatherings in compliance with recommendations for preventing the spread of COVID-19. Staff also moved to saliva testing instead of the more traditional urine drug screens because saliva swabs could be performed in a parking lot and did not require patients to enter the buildings. Support groups were restarted in June as soon as reopening began, and a suitable space could be arranged at the Willow Street location. CCFHS reports that this was not an ideal situation because primary care was not on site. Providers felt it was necessary to bring groups back together in person, however, because they were hearing from patients that they felt their recovery was lacking the structure provided by these support group meetings and increased the risk of relapse.

CCFHS notes that previously reported concerns about differences in MAT practices between CCFHS and the Doorway at AVH have been resolved during the reporting period and they are seeing less movement of clients between the two programs. CCFHS also notes that they now have quite a few prescribers on staff and are very mindful of the recent relaxation of prescribing requirements for buprenorphine, so are hoping to bring others into that role. The organization has also focused efforts during the reporting period on finding better ways to support staff in this work and helping them develop a better sense of personal boundaries and helpful perspective. In February, the practice gained an experienced Psychiatric APRN with a strong background in integrated behavioral health and she has provided valuable mentoring to staff in this regard.

As reported by other Region 7 IDN partners working within the SUD treatment realm, CCFHS has seen a worrying increase in the number of people using crystal meth in recent months. Individuals using crystal meth present with different behavioral and clinical concerns, and a well-established treatment method for individuals using that particular substance is not yet available. The practice is also mindful that COVID-19 has made daily life much more difficult for people living with SUD. Through the Granite United Way, CCFHS received some additional funding to help with meeting people's basic needs, and during the reporting period have expended upwards of $10,000 on groceries, rent, car expenses, and other daily needs in order to help individuals struggle less through the pandemic.

Friendship House (FH)

During the beginning of the reporting period, after several months of being closed, Friendship House (FH) reopened their 3.1 Residential Services at limited capacity. The team began using a soft opening approach, limiting residential services to six clients initially. This allowed FH to ensure that COVID-19 risk mitigation strategies were implemented effectively and test the new workflows and protocols related to the protective guidelines. FH has been using repeated PDSA cycles to inform a strategy for opening more beds in the future. Telehealth capability has kept the Outpatient and Intensive Outpatient (IOP) programs going and augmented social distancing practices in the residential programs. The partner increased collaboration with the Wellness and Recovery Model (WARM) team at North Country Health Consortium (NCHC) to improve coordination of care and provide necessary resources to clients waiting for an open bed.

After weeks of intense work to improve workflows to address the pandemic, the North Country Health Consortium (NCHC) announced the decision to seek another home for the SUD Clinical Services programs, including the residential programs at the Friendship House. The NCHC Board of Directors

made this decision with a plan for full transition by the end of December 2020. NCHC reported that it has been a continuous challenge to cover costs for the high-quality services delivered, which was significantly magnified by the COVID-19 Pandemic. The Governor has allocated CARES Act funding to NCHC that will allow the programs to remain open through the end of December, and NCHC worked with the State and the community to identify potential providers of these critical services in the North Country.

Despite NCHC's transition away from Friendship House operations the organization continued to provide services to individuals throughout the region and regional partnerships remained strong during the transition process. The building and grounds of the Friendship House remained the property of Region 7 IDN Partner AHEAD, Inc., and AHEAD has identified Amatus Health to provide services within the Friendship House building. At the time of this report, Amatus Health had signaled an intent to open detox, continue with 3.5 and 3.1 residential services, outpatient services and more. They stated a goal to have 100 days of treatment and then aftercare/outpatient for each client. Amatus Health currently has two locations in NH, and several others in a variety of states. They reported being in the process of expanding their Medicaid enrollment paperwork and applying for the residential license and noted that providing transportation is part of their business model.

At the end of the reporting period, NCHC formally withdrew the clinical services programs at Friendship House from Region 7 IDN as a result of the closure. Region 7 IDN partners are anxious to see these services continue in the North Country and look forward to forging strong new relationships with Amatus Health as they establish their program in this part of the state, and workers displaced by the closure of NCHC operations were provided the opportunity to apply for openings Amatus Health anticipated having in their North Country program.

Recovery resources continue to exist and are accessible in the area. NCHC's Wellness and Recovery Model (WARM) will continue to connect those in need of recovery services with specially trained Community Health Worker/Recovery Coaches. In addition, NCHC's AskPETRA program is available by phone, text, and webchat at AskPETRA.org to share resources and connect people in need with treatment and recovery services in the area, at no charge. More resources are on the way with NCHC's newest grant to address Neonatal Abstinence Syndrome with outreach to pregnant women, mothers, and women of childbearing age who have a history of, or who are at risk for, Substance/Opioid Use Disorder (SUD/OUD).

Hope for NH Recovery (Hope)

During this reporting period, Hope's Berlin site remained closed due to COVID-19 and lack of capacity to provide services. Hope remains operational at their central office in Manchester but stated at the end of the previous reporting period that it does not feel that it is feasible to reopen a center in Berlin at this time. Hope for NH Recovery was contemplating withdrawal from the Region 7 IDN for the remainder of the demonstration because they are no longer able to be active in the region however a formal withdrawal has yet to occur.

Huggins Hospital

Huggins Hospital continued providing Medication Assisted Treatment services this reporting period, serving an additional 19 patients since July 1. They report that their new electronic medical record system, Allscripts, has allowed them to be more consistent and up to date in their program reporting and data analysis. The prescribers in the MAT program now offer MAT at five of Huggins' six outpatient clinics and continue to work closely with both the Huggins social worker and professionals at Northern

Human Services to ensure that MAT patients have access to behavioral health services. Huggins has also begun participation with an initiative facilitated by the Foundation for Healthy Communities aimed at providing integrated SUD services in the inpatient setting. Efforts are currently underway to codesign interventions that allow inpatients with SUD to start the MAT program while they're in house.

White Horse Recovery & Behavioral Health Services (WHR) continues to provide peer recovery support to Huggins' MAT patients. During the reporting period, Huggins began discussions with WHR and Mount Washington Valley Supports Recovery to collaborate on the expansion of the 24/7 Recovery support services project into the Huggins Emergency Department. The Huggins team has also contracted with North Country Health Consortium's Ways to Wellness CONNECT (W2WC) team and the Wellness and Recovery Model Team as part of the program's expansion into Carroll County. These two initiatives have proven themselves across the region and are positioned to help Huggins staff continue to provide efficient patient care to Behavioral Health and patients struggling with SUD.

Littleton Regional Healthcare (LRH)

LRH continues to operate one of the two Doorway sites for the North Country Region. LRH has continued to successfully provide Substance Use Disorder with clinical services at their location. Unfortunately, an update from the Doorway at LRH regarding activities during the current reporting period was not available in time to be included in this report. The team at LRH's North Country Primary Care (NCPC) reports that primary care providers continue to use the PHQ-9 as a screening tool and facilitate referrals to the Doorway as well as other SUD programs in the region, however the LRH physician practices do not currently have a formal referral agreement in place with the Doorway. No additional updates have become available during the review period.

Memorial Hospital

During the reporting period, Memorial Hospital has continued to offer the Integrated Medication Assisted Treatment (IMAT) program through a telehealth model but suspended in person services during the pandemic. Memorial reports that they continue to use the peer recovery services in their emergency department but continue to see individuals in need of placement wait eight to ten days in the Emergency Department before beds become available, and experience that is traumatic for both patients and staff. Most often, these individuals are either boarded for suicidal ideation with a comorbid SUD diagnosis, or have an opioid use disorder and need detoxification and rehabilitation. Under the auspices of parent organization Maine Health, Memorial has recently asked the NH Department of Health & Human Services for a waiver to place patients at Maine Health facilities in the state of Maine. Memorial also reports that their facility will be expanding program capacity by adding a new full-time provider to the SUD team.

Mount Washington Valley Supports Recovery (MWVSR)

Mount Washington Valley Supports Recovery (MWVSR) continued their collaboration with White Horse Recovery Services (WHR) on their shared 24/7 on-call emergency recovery coach service. The partners spent the reporting period working on plans for the future of the project. After successfully piloting the program at Memorial Hospital, they are now working through protocol development to spread services to Huggins Hospital. Memorial Hospital Emergency Department leaders report that the services have cut hours from evaluation and discharge plans from an ER visit for those presenting with SUD, reducing the burden on Emergency Department providers. This initiative, which started with the support of IDN funding, is being sustained through other funding sources pursued by both partners. Memorial Hospital Emergency Services sent a letter of support for a two-year grant from Granite State United Way and has asked the partners to continue the service.

MWVSR also spent the reporting period assisting a MLDAC entering private practice with credentialing through Harbor Care, by linking them with Groups Recovery Together and Cranmore Health Partners that is providing MAT at their new facility. MWVSR are encouraged that this new provider will be able to run individual sessions, IOP and evaluations for the community while collaborating with the Recovery Community Organizations, the MAT providers, Drug Court, and other community care providers starting before the end of 2020.

MWVSR reports that they experienced a 30% cut from Harbor Care last year and are now hearing that there is a possibility that the organization will lose funding completely for this year. At this point in time, they have completely lost all overhead support, and the decision about continued support from Harbor Care will be made at the end of the fiscal year in June. MWVSR has made a request to the State for State Opioid Response funding that could bring them back to a level of stability, and reports that the final round of funding available through the Region 7 IDN Transition Plan will secure financial stability for the first six months of the next fiscal year. As a result of the financial challenges experienced during the reporting period, MWVSR has laid off 2 recovery coaches and are hoping to rebuild the team once the pandemic activities resolve as vaccinations become more widespread. The leadership at MWVSR realizes that this may mean that they have staff who are brand new to peer recovery work, and that it can take up to a year for inexperienced staff to complete the Certified Recovery Support Worker training and supervision hours.

MWVSR reports that they now respond to at least one call from Memorial Hospital Emergency Department (ED) for recovery services and working to help those individuals access residential programs as quickly as possible. During the reporting period, MWVSR notes that they have seen a flip in needs, with the upwards of 75% of calls now involving alcohol misuse rather than opioid misuse. Anecdotally, it appears that alcoholism that was maintained socially is now negatively affecting people during the COVID crisis. The age group most often seen at this time is the 30–60-year-old group, rather than the 18–24-year-olds seen with opioid use disorder. MWVSR also notes seeing more males than females at ED, and an emerging trend of more methamphetamine interactions as well. The methamphetamine use poses new issues because patents present with psychological symptoms that slow interactions with SUD providers until the psychoactive symptoms are resolved. In response to this emerging trend, MWVSR is encouraging staff to attend trainings related to methamphetamine overdose and alcohol use disorder.

MWVSR continues to operate a needle exchange program but notes that engagement is down with no outreach for over a month for the harm reduction program. The organization has developed great COVID and wound care kits and staff are planning to take them out when they participate in the Point in Time homelessness count in January. There are no syringe clients at this time, but MWVSR intends to reignite contracts with Saco River Medical Group and White Mountain Community Health Center after the COVID vaccination phases are complete to get Hepatitis B and Hepatitis C testing underway. MWVSR also wants to complete trainings with the harm reduction coalition as soon as possible. They express concern that they have been challenged to get people to come into their facility during the pandemic, suspecting that individuals struggling with SUD have gone underground, and without meaningful connections to supports and services they are more likely to relapse and/or overdose.

Staff at MWVSR remarked that they do think that more people are reaching out for help through the ED knowing that they can go to Memorial and it will be a safe place to go and that the services will be available there. This is important because it provides individuals with access to the medical attention they need and then they can move forward with the peer recovery coaches to get into treatment. They state that the community knows now that they will not be brushed aside at Memorial, and that recovery

coaches will meet them in the ED to start services. The credit the coach that was sent to the ED for forging strong relationships with the ED staff that have built trust with both clients and hospital workers.

Endeavor House continues to be operated by MWVSR, with a state contract for two beds. Endeavor House has been full since thanksgiving because they are limited to a census of six. MWVSR is waiting to undertake a renovation that will allow a census of twelve guests, but that will require a house manager that the agency cannot afford to pay at this time.

North Country Health Consortium (NCHC)

NCHC's Wellness and Recovery Model (WARM) team has continued working to provide clients with recovery support services throughout the reporting period. During the pandemic, the team lost one trained recovery coach (RC) but continued direct service delivery with the team of three other staff. The WARM team continued to support Friendship House during their transition back into residential services. CHW/RC helped provide Friendship House clients with education around harm reduction, endocarditis and bloodborne pathogens while also assisting them with finding access to adequate housing and addressing other needs related to Social Determinants of Health while they remained on the admission waiting list. The agreement continued to engage the WARM team to provide aftercare support for Friendship House clients and help with data collection for the remainder of the year while organizational transition begins.

The WARM team has been adjusting to the transition of recovery support services to a virtual setting which remains HIPAA and CFR 42 Part 2 compliant. They have continued using a combination of telephonic services and some Zoom capabilities to serve clients during the reporting period. The team continues to collaborate with local clinical partner agencies to accept referrals for case management services. ACHS remain a significant partner in these efforts as this FQHC continues to adjust to loss of the CHW and Behavioral Health Case Manager positions. The WARM team also continued efforts to collaborate with local Recovery housing organizations to provide support for individuals who have been discharged due to relapse or choice. The relationship between WARM and Family Resource Center continues to help WARM clients participate in FRC programming seamlessly.

The WARM team continued collaborating with the Recovery Community Organizations in the region to explore and create training opportunities to address the needs of recovery coaches and other support service staff as they work to help clients reach their recovery goals. After receiving Connecticut Community for Addiction Recovery (CCAR) approval in late June the WARM team held the first virtual Recovery Coach Academy Training in August 2020. The WARM Team reports that they successfully held a Naloxone Training of Trainers in partnership with Ryan Fowler through the HIV/HCV resource center and The Claremont Exchange virtually in August as well.

Through the summer, the Team also met with Northumberland select board to discuss the idea of a Recovery Oriented Policing Model (ROPM). In September, the select board approved the model and since then, two educational sessions have been provided in that community to further the effort. A Recovery Coach Bootcamp 3-hour training kicked off the effort and in December a 5-hour primer in all sections of the Recovery Coach Academy was provided by the WARM Team to meet deliverables to the town by delivering a total of eight hours of ROPM training this reporting period. They are now constructing the model, and have stated an intent to have every officer, the Chief and the Administrative Assistant trained as recovery coaches. Chief Pelletier has been credited with the cultural shift, stating that he realized, "I can't arrest my way out of this problem." Has also added several new officers who are oriented in community policing models.

In August, the WARM Team held a Recovery Coach Academy virtually, with partners as far away as Easter Seals in Manchester joining Region 7 IDN partners like the Family Resource Center (FRC) and other community members in attendance. In September, Ethical Considerations for Recovery Coaches was offered virtually and was also well attended by FRC and Easter Seals staff. HIV and Infectious Diseases was held in October and Suicide Prevention in December. In addition, the WARM Team provided a 90-minute Suicide Prevention presentation for NH CHW coalition and hosted the "HIV: Let's Face It" 4-part Community Education Series, facilitated by NH Listens, during the reporting period. WARM also reports that, at this time, almost all of the team has successfully completed the 25 hours of supervision necessary to apply for Certified Recovery Support Worker status.

Work by the North Country Trainer's Collaborative, which serves as the Recovery Community Organization Advisors Group, has continued through the end of the year. This group has representation from across Region 7, and dedicated efforts during this reporting period to further enhancing a periodic newsletter to the community. This collaborative effort is a partnership between NCHC, WHR, FRC, NCSC and White Mountain Recovery Homes. A new section of the newsletter called Recovery Spotlight was recently introduced, in which the recovery journey of a community member is highlighted. This newsletter is distributed to all people who have been trained as recovery coaches by NCHC and each issue is centered around a featured topic (i.e., connectedness during pandemic, virtual supports), offering tips and strategies related to the topic and a listing of upcoming trainings. FRC collaboratively writes a Parenting in Recovery article for each newsletter, and PETRA and CHW Coalition spotlights are offered as well.

NCHC is also a recipient of an NAS grant that has allowed PETRA to develop a strong collaborative relationship with the Coös Coalition for Children, Youth and Families, a regional group that focuses on early child development in Coös County, including early child education. They anticipate that the WARM for Women program will focus heavily on family centered supports and education services.

Finally, the WARM team continued to support the AskPETRA program created by the North Country Health Consortium under a grant from the Health Resources and Services Administration that is designed to help adults, communities, and professionals in Northern NH to understand, prevent and treat SUD through assistance, connection, education, and recovery support. AskPETRA and WARM staff have utilized the newly developed COVID-19 resource directory and SUD directory to fill care gaps and improve collaborative care with external partners. AskPETRA is working to collaborate with the Claremont Exchange and the HCV/HIV Resource Center to explore options for Harm Reduction services in northern Grafton and Coös Counties. The program also focuses on providing education and awareness about bloodborne illnesses such as Hepatitis C, HIV/AIDS, and endocarditis, with the goal to promote the integration of treatment services for people with these diseases – a treatment service not universally available in the region.

North Country Serenity Center (NCSC)

North Country Serenity Center continues to support the recovery community throughout the region despite ongoing pandemic barriers. NCSC currently employs 5 people but is lacking a receptionist to help assist with day-to-day functions and COVID-19 protocols, necessary to follow, to remain open to the public. This unfilled position is a result of a lack of financial resources to fulfill payroll obligations. Nonetheless, the RCO has had success working within the network to improve wrap around services for clients. The main barrier NCSC is experiencing is being able to assist clients with establishing PCPs in a timely manner. NCSC has worked with many participants that are experiencing long wait periods to become established with a new Primary Care Doctor in the area. The recovery coaches have been

working with clients during these waiting periods and have had remarkable success in referring clients for LADC and mental health services.

NCSC has continued to leverage the relationships established through the IDN to connect clients with other partners, as necessary. During the reporting period, NCSC staff helped a client set up services with TCCAP to become eligible for housing assistance and established extra support from the ACHS medical. NCSC assisted the client with apartment searching and completing applications. NCSC experienced that a lack of housing availability has become the biggest barrier to success for some clients.

North Country Serenity Center continues to experience significant challenges providing support groups because COVID-19 has made it impossible to hold large groups within their current space. Regardless, the recovery support team has provided services virtually during the reporting period. The agency also met with North Country Recovery Center (NCRC) and is working to create an efficient referral process to quickly help clients get established at NCRC for Medication Assisted Treatment services.

NCSC also reports that two employees were laid off during COVID with the anticipation of not bringing them back. Shortly after that, the state became aware of concerns about whether work was being performed as reported, and the agency is now under a corrective action plan with Harbor Care regarding the lack of timeliness in invoicing and reporting. As a result of the investigation, significant staffing changes were made at all levels of the organization. NCSC reports being in the process of enrolling as a Medicaid provider and working towards CAPRS accreditation. As with MWVSR, this recovery community organization is also facing funding cuts from Harbor Care that jeopardize their ability to serve the community. At the time of this report, the NCSC board is investigating the potential to merge operations with another, more stable, agency in the region at some point in 2021.

Despite these challenges, NCSC has been able to maintain telephonic recovery supports and recovery coaching. Staff report that they have moved most meetings to an online format, and have found that the 12 step programs, especially, have flourished in that format. Other programs such as 3Ps, All Recovery, their men's group and the Four Agreements meetings have struggled more, and they note that many participants particularly miss the social aspect of being able to drop into the center at any time. The building has been closed since November 30 as NCSC works to address some building code issues, but the center looks forward to resuming services on site as soon as possible.

NCSC staff note that it has been discouraging to work with that portion of their client population who lack the technology to connect to supports online. They also note that the challenges experienced during this reporting period have also led to some fractures in connectivity with other partners in the region as MOUs have expired and not been renewed. The relationship with ACHS, however, has continued with cross referrals between both agencies and a good working relationship between staff.

In the fall, significant effort was made by the remaining staff to carry out yearly traditions with adaptations for COVID, including an overdose awareness event that included Narcan training and a candlelight vigil. Recovery month in September brought a recovery event of a family fun field day, spreading out different activities in a COVID safe way. Families played different games and instead of a buffet lunch, brown bag grab and go lunches were offered to families. In October, NCSC held a scarecrow building contest, also with COVID adaptations. Staff report that events have been well attended and for each of them, volunteer committee members were actively engaged in the planning and execution. The pandemic meant that they could not hold their usual large annual field day event, so it was nice to supplement with these smaller events.

Northern Human Services (NHS)

During the reporting period, NHS continued to provide SUD treatment services to Coös County residents working with the Coös County Drug Treatment Court and offering outpatient LADC services throughout the region. NHS has continued using telemedicine for outpatient services but was able to continue with in-person visits for Drug Treatment Court clients in Coös and Carroll Counties. NHS also has three licensed mental health counselors who are near completion of required supervision hours provided by the CMHC so that they can become dually licensed and earn their MLADC status by the end of the year. In November, NHS moved most services to a telehealth model as COVID case counts rose across the region, noting that the IOP program was most heavily impacted and is currently not operating.

Saco River Medical Group (SRMG)

SRMG continued providing Medication Assisted treatment services to its patients throughout the reporting period. The partner experienced staffing changes during the summer as one of their physicians resigned and a new nurse practitioner was onboarded. SRMG also supported another provider has obtained a waiver to prescribe Medication Assisted Treatment, allowing the practice to maintain two MAT providers. The pandemic has continued to impact staffing at SMRG, as several clinical support staff resigned due to concerns about possible COVID exposure. While the practice has continued to offer in person services, as the reporting period progressed it implemented more telehealth appointments to accommodate both patients who preferred that mode and the need to ensure that adequate physical distancing could be maintained in the office. In the second half of the reporting period, SRMG lost one of their three MAT waivered providers, but have been able to maintain services for the more than 100 patients who remained enrolled with the remaining providers. SRMG continues to collaborate with Mount Washington Valley Supports Recovery to guide the care of their mutual patients and relies heavily on the behavioral health services of White Horse Recovery & Behavioral Health Services for their MAT patients. The partner is also positioned to collaborate with other local agencies through the Carroll County proposal approved by the Steering Committee during this reporting period.

Weeks Medical Center (WMC)

WMC continued to provide SUD services through the North Country Recovery Center (NCRC) and serve as a subcontractor to provide staffing for the Doorway at Androscoggin Valley Hospital (AVH) throughout the reporting period. No update was available from this partner for the current reporting period, largely due to the significant work underway at the facility to implement a new electronic medical record system and serve as one of the state's COVID testing centers. No additional updates have become available during the review period.

White Horse Recovery Services (WHR)

White Horse Recovery Behavioral Health Services (WHR) continued to provide an array of Substance Use Disorder and Behavioral Health Services throughout the reporting period, despite the ongoing barriers the COVID pandemic has caused. WHR has been able to engage as needed with individual primary care providers and manage internal cross disciplinary effort between their own mental health and SUD clients. The partner also added SMART recovery groups and began training a CRSW as a Community Health Worker to provide more resources to clients throughout their region. WHR has continued to face challenges getting staff licensed and reports that communication with the licensure board has been made worse due to the pandemic, however WHR continues to focus on recruiting fresh staff and training current staff to ensure the delivery of quality care to all clients.

The partner continues to struggle to secure affordable housing for the new hires due to the affordable housing crisis in Carroll County that has been made worse by owners of second homes in the Mount Washington Valley and Lakes Region who have permanently moved into the area away from the urban centers of Boston and New York City. Previously, some of these homes were available as long-term rental inventory but they are no longer a resource that employers can rely on. WHR reports that they risk losing these candidates if housing cannot be secured soon.

WHR continued the partnership with Mount Washington Valley Supports Recovery to offer 24/7 emergency services in Carroll County. After successfully piloting the program at Memorial Hospital, they are now working through protocol development to spread services to Huggins Hospital. Memorial Hospital Emergency Department leaders report that the services have cut hours from evaluation and discharge plans from an ER visit for those presenting with SUD, reducing the burden on Emergency Department providers. This initiative, which started with the support of IDN funding, is being sustained through other funding sources pursued by both partners. Memorial Hospital Emergency Services sent a letter of support for a two-year grant from Granite State United Way and has asked the partners to continue the service. WHR's CEO is now chairing the Governor's task force to support 24/7 recovery supports in all NH Emergency Departments.

WHR's Intensive Outpatient Program has maintained the client load virtually, offering Zoom options for clients uncomfortable coming in for in-person visits during the reporting period. Group recovery meetings were held outside whenever possible, allowing clients in-person connection over a cup of coffee. WHR also referred clients to a local Medication Assisted Treatment program for which WHR behavioral health professionals provide counseling services. The partner has also been working with Memorial Hospital, Saco River Medical Group and Northern Human Services regarding collaborative care.

During the reporting period, WHR has continued its 4-year engagement with the Kingswood Youth Center as a Wednesday volunteer, planning activities for the students that attend the after-school programs. WHR has regularly donated time and resources to the program, including exposure to SUD treatment careers, occasionally bringing a LDAC or LCMHC to the center to discuss their careers with the students or clients to share their recovery journey as a prevention intervention. This year, WHR has expanded to help start a program in Center Ossipee at the Center Ossipee Community Center. They have also begun helping Carroll Country with transport of people being released from the county jail to get to their respite locations. Just hired a new Clinical Director two weeks ago – will have a significant impact on the project with the IDN.

White Mountain Community Health Services (WMCHC)

WMCHC continued to provide Medication Assisted Treatment services to patient throughout the reporting period. Patients who need frequent urine drug screens come into the office for that specific service and then participate in the actual provider visit via telemedicine. MAT is almost 100% telehealth as a result. A second APRN at the practice has received her MAT waiver, increasing the capacity of the clinic.

Carroll County Coalition for Public Health (C3PH)

C3PH continues serving as a connector and facilitator for Carroll County partners working to address the Opioid crisis in the context of a pandemic. The organization was asked to gather key Carroll County partners during this period to develop a proposal to utilize IDN funds to support continued collaboration past the DSRIP period. Representatives from C3PH, White Horse Recovery Behavioral Health Services,

Mount Washington Valley Supports Recovery, Memorial Hospital, Huggins Hospital and the NCHC WARM and AskPETRA programs met to identify opportunities to expand the initiatives that Carroll County partners currently have in place or are working to implement, with a focus on integrated services and workforce development.

This proposal places emphasis on those services and supports that can be shared and interwoven into the Carroll County partner's initiatives to increase their scope and ensure sustainability. C3PH is prepared to act as a fiscal agent and subcontract resources so that Carroll County IDN7 partners can carry out activities over two years that will increase awareness of, increase access to and expand capacity for regional substance use services. The Steering Committee approved their proposal, and a MOU was executed in mid-December.

Project Targets

Use the format below to provide a list of all of the progress toward targets that the program has achieved. Targets should include.

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

Performance Measure Name	Target	Progress Toward Target				
		12/31/18	6/30/19	12/31/19	6/30/2020	12/31/20
New MAT services in Region 7	3	3	5	7	9	9
Individuals served with new MAT services in Region 7	35	28	211	591	754	1001
New sites offering intensive outpatient (IOP) services	1	0	1	4	3	2
Individuals served with IOP services	144	156	189	280	429	338
Existing IOP providers expanding services	3	1	2	4	4	3
Trained Peer Recovery Coaches	6	67	88	88	35	22
Individuals served by Peer Recovery Coaches	50	222	480	975	1787	3582
Staff recruited and trained vs. projected	31	116	148	148	142.5	117.5
Individuals served vs. projected	229	406	880	1594	2970	4921

As noted in the Project Plan Implementation (PPI) section of this report, many partners in Region 7 have dedicated considerable time and effort during the reporting period working to ensure that their most vulnerable patients and clients remained connected to services. As a result of COVID-related disruptions, not all partners have been able to dedicate time to producing quantitative data that informs this report, or to sharing detailed narrative reports of their work. Reporting gaps remain, so some of the performance target aggregate totals may have decreased over the last two reporting periods. These regressions may reflect staffing losses and reductions or be the result of incomplete data sets.

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting. In your narrative please also speak to any variances from your proposed cost to your actual spending.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	1/1/2019 - 12/31/2019	1/1/2020 - 6/30/2020	7/1/2020 - 12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
SUD	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June ACTUAL	CY 2020 July to Dec ACTUAL	CY 2020 ACTUAL	CY 2021 Projected
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants									
5. Supplies:									
Educational									
Office	$968	$147	$116	$95	$211	$73	$20	$94	$38
6. Travel		$368	$202	$202	$405	$44	$94	$137	$94
7. Occupancy									
8. Current Expenses									
Telephone									
Postage									
Subscriptions									
Audit and Legal									
Insurance									
Board Expenses									
9. Software		$443	$238	$386	$624	$134	$113	$247	$95
10. Marketing/Communications	$1,086	$2,369	$179	$192	$371	$17	$1	$19	$9
11. Staff Education and Training		$522	$272	$272	$544	$188	$66	$253	$66
12. Subcontracts/Agreements									
13. Other (specific details mandatory):									
Current Expenses: Administrative Lead Organizational Support	$1,634	$2,236	$294	$275	$569	$158	$91	$251	$88
Support Payments to Partners	$65,766	$103,325	$26,708	$41,407	$68,115	$9,047	$17,189	$26,236	$97,657
TOTAL	**$91,231**	**$140,409**	**$50,737**	**$61,798**	**$112,535**	**$24,629**	**$29,616**	**$54,247**	**$105,771**

At the beginning of the demonstration, Region 7 opted to take the approach of budgeting based on how incentive payments are earned. This approach has been used for staffing as well as partner requests for funds and was adopted because partner proposals and staff time often touch multiple DSRIP projects concurrently. Expenses have therefore been allocated as a flat percentage across project areas, with the region setting out initially to roughly budget the funding across projects in parallel to the proportions in which the incentive payments were earned.

As funding uncertainties mounted in 2018 and 2019, the region maintained the original allocation rather than making the shift in the weighting from the state-wide projects to the core competency project. This has resulted in allocations of approximately 42% of funding to state projects, 36% to the core competency project and 22% to community projects for the life of the DSRIP. Proposed expenses for the remainder of the demonstration include anticipated costs for infrastructure staffing, subscription to the Collective Medical Network and distribution of remaining earned incentive payments to partner organizations in support of their ongoing work to meet the goals of the DSRIP. Variances experienced to date include:

- Reductions in incentive payments available following decreased county contributions for years 3 and 4.
- Failure of the region to meet 100% of incentive payment targets for both process and performance measures.
- The restructuring of infrastructure staffing in line with decreased funding earned by the region, the rationale being that if there was less money available for partner organizations, the infrastructure team should be similarly reduced.

Projects E: Integration Focused

Narrative

Provide a detailed narrative which describes the progress made during this reporting period.

Network Membership

During the reporting period of July 1 through December 31, 2020, one partner, NCHC Clinical Services/Friendship House, left the network, bringing the total number of partners in the Region 7 IDN to thirty-eight (38). The information below speaks to the progress that Region 7 IDN has made on the E5 "Enhanced Care Coordination" community project during this reporting period.

Key organizational and provider participants

Organization/Provider	Agreement Executed (Y/N)
Ammonoosuc Community Health Services	Y
Coös County Family Health Services	Y
Huggins Hospital	Y
Indian Stream Health Center	Y
Memorial Hospital	Y
North Country Health Consortium	Y
North Country Healthcare	Y
Northern Human Services	Y
Saco River Medical Group	Y
Weeks Medical Center	Y
White Mountain Community Health Center	Y
Saco River Medical Group	Y

Regional update

As stated in the Region 7 IDN implementation plan, the goal during this demonstration was to promote a regional care coordination approach by training care advocates across the region. The region aspired to train at least 15 Care Advocates; place one regional Care Advocate supervisor in the region to assist these Care Advocates with their ongoing professional development; and serve at least 45 individuals with enhanced care coordination by the end of the demonstration. The region also set a goal to develop a Care Advocate work group that would develop a toolkit of care coordination tools and protocols to facilitate the delivery of enhanced care coordination and encourage the use of evidence-based practices among care coordinators around the region.

During the reporting period, work continued on the development of a Regional Care Coordinator Network (RCCN). Care Advocates and care coordinators from around the region began this work at the end of 2019 and started the current reporting period with the intention to become a cohesive peer cohort who would work together to enhance skills, improve communication about shared patients or clients, and continue to deepen the level of engagement with social service organizations.

The introduction of a pandemic early in the previous reporting period changed the way care advocates were able to provide enhanced care coordination services to high-risk populations. Many clinics and hospitals closed, at least temporarily, to in-person appointments and admissions as patients sheltered at

home instead of seeking care. Although this impacted care coordination in the region, ambulatory practices worked diligently in the early days of the pandemic to stand up telehealth services and intensify patient outreach to ensure social determinants of health were being addressed and patient needs were being met.

During the reporting period, the Region 7 IDN team continued its efforts to connect with partners on a regular basis and leverage the network to improve access to critical services. This included continuing weekly COVID Touch-Base town hall style meetings throughout the remainder of the reporting period. As operations normalized for most partners in the fall and they found themselves well informed about resources within their local communities and at the state level, attendees opted to reduce the call frequency first to a bi-weekly and then monthly cadence. Representatives from NH DHHS and the Medicaid Managed Care Organizations (MCOs) were continued to participate in these calls in an effort to ensure a timely awareness of barriers and successes experienced by Region 7 IDN partners as they worked to address the needs of their community members in the state of the pandemic.

While not specifically listed as a key partner on this community driven project, the Carroll County Coalition for Public Health (C3PH) has continued to be a critical partner to Enhanced Care Coordination partners in Carroll County during the pandemic. Through their work as both a Public Health Network and Region 7 IDN partner, C3PH is uniquely positioned as a connector and facilitator between health and social service organizations in Carroll County. During the pandemic, C3PH has assisted several community-based organizations in Carroll County maintain mechanisms, disseminate information, running errands, and support hard to reach families. In the northern part of Carroll County, C3PH assisted the Gibson Center for Senior Services coordinate outreach into the elderly population that has largely stopped visiting the center during the pandemic. These elderly members of the population typically access the Gibson Center for congregate meals and social connections, so outreach has ensured that they continue to maintain good nutrition and social connection while also protecting their health by staying home. C3PH also continued to work with key organizations in to produce regular information sessions for the community in virtual environments like Zoom and Facebook Live.

Ongoing Care Coordinator Skills Development

The Region 7 IDN Regional Care Coordinator Network (RCCN) continued to serve as a vehicle for the support and skills strengthening of the Care Coordinators and Care Advocates in the region. The development of the RCCN has continued to provide care advocates across the region with a peer cohort that serves as an asset for collegial communication, support, and access to resources to further enhance care coordination within the region.

During this reporting period the RCCN convened virtually on August 12, September 19, October 14, and November 11, continuing discussions regarding current care coordination work throughout the region. The group also discussed successes, challenges, and resources available to address current needs. During these discussions, the Care Coordination team stated that lack of bandwidth continued to impact collaboration, education, and professional development related to care coordination. The COVID-19 pandemic remains a strong consideration for all departments with normalizing schedules/staffing and staff members continuing to be retasked to COVID activities and healthcare organizations have experienced financial downturn. The reality of this added burden continues to shift the meetings away from professional development to focus on staying updated on what is happening with care coordination at partner organizations.

Partner specific updates

Generally speaking, during this reporting period partners altered the way in which they were collecting information about social determinants of health and enhanced care coordination needs from their patients as they flexed their operations to respond to the COVID pandemic. They did not always follow protocols and workflows that had originally been put in place under the demonstration, but in general their efforts to identify patient/client needs intensified and they were able to connect these individuals to the social service organizations in the community who could address social determinant needs. More detailed information is provided in the partner specific updates below.

Ammonoosuc Community Health Services (ACHS)

ACHS reports that they are currently trying to figure out how to make sure that care plans related to social determinants of health are noted in the record in consistent ways such that the patient navigators and care management are looped in to handle referrals to the services that are needed. While ACHS has long had the Core Comprehensive Standardized Assessments themselves hard wired into the record, this step will take the information buried in the encounter and more automatically connect it to the folks that can help get the services in place to address the positive findings. The remainder of AHCS' strong enhanced care coordination processes are continuing through the pandemic, including intentional outreach to the most at-risk patients to ensure that their chronic conditions continue to be well managed.

During the reporting period, ACHS expended additional care coordination effort to connect COVID positive patients who were not hospitalized with the care coordination team. Through this process, ACHS staff have ensured that these patients had pulse oximeters at home and provided symptom screenings and follow-up appointments in the parking lot under a tent to monitor their conditions. The primary goal for this specific population was to identify those patients most at risk of or vulnerable for significant complications of COVID-19 and monitor them closely. Additionally, ACHS staff worked with these patients to ensure that they had and understood their Advance Care Planning Documents in case hospitalization occurred and they lost capacity for medical decision making. As the reporting period ended, the team began early identification of the vaccination eligibility for their patient population. For the general patient population, the ACHS team worked to ensure that the pandemic had minimal disruption to normal preventative care, reminding patients of the importance of adhering to recommended guidelines for cervical cancer screening, mammograms, and colon cancer screenings.

Coös County Family Health Services (CCFHS)

CCFHS continues to share a care coordinator with the local hospital. During the pandemic, this care coordinator noted that there was an increase in referrals to the social worker to address basic needs like food and access to cell phone minutes so patients could initiate unemployment claims. Two of the State's managed care organizations donated over 100 emergency food and supply bags which were distributed by CCFHS staff. AmeriHealth Caritas and New Hampshire Healthy Families also made large donations to the Great Northwoods Charitable Foundation, a shared venture between Region 7 IDN partners CCFHS and Androscoggin Valley Hospital (AVH). These monies have been used to purchase and distribute emergency supplies, purchase cell phone minutes and stock local food shelves. During the reporting period, Granite United Way also donated $10,000 to the community which has been used to purchase the supplies and services for families who would otherwise violate isolation and quarantine orders.

During the reporting period, CCFHS continued to identify patients who were poorly connected to technology and therefore less able to participate in telehealth visits, so telephonic contact has continued with those most at risk for both the decompensation of their chronic diseases and complications from COVID-19. For much of the pandemic period, Coös County remained largely untouched by the virus, but in October case counts began to spike alarmingly, particularly in the Berlin-Gorham area. Community transmission was linked to social gatherings in the region, and in response to the rapid increase in case counts CCFHS spearheaded a reconvening of a multi-sector group that has mounted an impressive collaborative response. Meeting daily, Androscoggin Valley COVID Response Team includes representation from CCFHS, AVH, local schools, business leaders, public health, nursing homes, Northern Human Services, state and federal prisons, social service organizations, municipalities, emergency medical services and field representatives for the region's US congressional delegation. Their open sharing of trends being witnessed in each sector allowed the community to coordinate focused testing, contact tracing and targeted messaging campaigns to the community to mitigate community transmission. This work has been highlighted by a number of media outlets, including New Hampshire Public Radio (https://www.nhpr.org/post/how-daily-zoom-call-became-lifeline-covid-response-nhs-north-country#stream/0), as a workable and highly effective multidisciplinary model.

During the reporting period, Care Coordination has continued to provide transitional and chronic care management services as time allows, focusing on patient discharges from hospitals and nursing homes. CCFHS, as the largest provider of primary care services to patients in the Androscoggin Valley, stood up COVID testing clinics that are collection several hundred samples each week on both adults and children. In addition to their usual processes, the care coordinators took on the herculean task of conducting contact tracing for their patients, often completing the process before the State of New Hampshire Division of Public Health Services had even received positive test results. This critical function of the Androscoggin Valley COVID Response Team has allowed partners in the community to identify and break transmission chains for sources of community spread quickly and effectively, preserving the capacity of the healthcare system in the region.

Care Coordination at CCFHS has identified that social determinants play a significant role in the likelihood of a family adhering to isolation and quarantine orders. This department has been particularly busy connecting families to the resources they need in order to have adequate food and resources to stay home for sometimes four weeks or more as COVID-positive individuals clear their infections and their family members quarantine for 14 days post-infection. As the reporting period ended, the staff at CCFHS dedicated time to readying the organization to be a significant participant in the delivery of COVID vaccine, based on their knowledge that almost half of the 12,000-person panel of CCFHS patients would likely fall into the early phases of eligibility based on the region's high proportion of elderly and chronically diseased individuals.

In the middle of so much work related to the pandemic, CCFHS also celebrated several notable events in their quest to ensure that the patients cared for at their clinics received the highest quality care possible. The clinic completed recertification as a Patient Centered Medical Home for all three clinic locations, an arduous process that requires submission of data and narrative reports reflecting their commitment to quality and patient advocacy. CCFHS' pediatrician Dr. Brian Beals was named Pediatrician of the Year by the New Hampshire chapter of the American Academy of Pediatrics in recognition for his dedication to the health and wellness of children in the region.

Finally, CCFHS has added a Certified Diabetic Educator (CDE) to its staff and has become accredited as a provider of diabetes education and a Diabetes Self-Management Program. This accreditation allows the

clinic to be reimbursed for diabetes interventions, which makes these services sustainable in the long term. CCFHS acknowledged that patients need time to digest the diagnosis and get help with all things related to diabetes, so feel that having someone on staff with expertise and time to guide patients through their disease management will be immensely helpful. The practice has already noted a drop in A1C results for the individuals that have been enrolled in the program. They are also extremely excited to be able to offer continuous glucose monitoring (CGM) as a service – technology that is understood to be a game changer for people with diabetes. This includes a subscription to Glooko, a web-based service that allows patients to share their CGM data with their providers so that they can help monitor the data and use it to make treatment recommendations.

Huggins Hospital (Huggins)

Huggins entered the reporting period with plans to upgrade its health information system and continue collaboration with other health and human service organizations in their catchment area as they worked to create a community health network in Southern Carroll County. Their role in the community as a Critical Access Hospital forced the organization to suspend several key service lines while it positioned the hospital to serve as an Alternate Care Site and prepare for a potential surge of COVID-19 positive cases. Staff in the Huggins care coordination and case management departments used this time to reevaluate their protocols and workflows and restructure the way they provide enhanced care coordination services. In the interim, Huggins has partnered more closely with social service organizations within the community to provide some of the case management and care coordination functions while their program is under redesign.

Huggins consistently participated in the weekly Region 7 IDN COVID Touch Base meetings convened by the IDN7 Team, and regularly mentioned concerns about patients with chronic conditions not seeking care due to their fear of contracting COVID. Providers and care advocates at Huggins are concerned that those chronic conditions are decompensating and some of the headway made through the provision of enhanced care coordination will have been lost by the end of the pandemic. Office staff have spent time calling patients known to have higher needs and higher risk throughout the pandemic to ensure their medical and social needs are being met. As the hospital began reopening ambulatory clinics at the start of the reporting period, patients identified as being high-risk were prioritized for the first in person visits. They have enrolled 67 new Enhanced Care Coordination patient since July and are now looking at ways to embed a care coordinator into each of their six practice locations one day per month, rather than maintaining a centralized model that keeps the care coordination team on the hospital campus. As part of the care coordination redesign, a Social Determinants of Health Coordinator has been named to the team and has been meeting with providers across all sites to raise their awareness of the program. The team is driving towards a patient goal-centered approach to care coordination, rather than one focused on the most task heavy patients.

During the reporting period, the Care Coordination department has developed an outpatient COVID monitoring program. Through this program, any patient testing positive is called on a frequency set by their level of risk of COVID complications, pulse oximeters are mailed overnight to patients, and they are monitored for worsening signs and symptoms. The Huggins team also has the ability to send monoclonal antibody treatments to high-risk patients and are seeing positive impact of this targeted intervention. The facility has also opened and maintained a Temporary Outpatient Services (TOPS) clinic for patients that need to be seen for respiratory and/or COVID-related symptoms but do not require Emergency Department care. The goal of these interventions has been to keep patients out of the Intensive Care Unit and off ventilators, heading off major problems before they start. As with CCFHS in

Easter Coös County, these primary care-based tactics employed by the team at Huggins have successfully managed the pressure on the rural healthcare system in southern Carroll County.

Huggins also reports that they are very appreciative of the opportunity to work closely with the Community Health Workers (CHWs) from the North Country Health Consortium's Ways to Wellness CONNECT program as a result of their expansion project funded by IDN7 during this reporting period. While the progress is slow at the moment due to the team not being able to meet with clients in their homes, strong telephonic support is being provided to favorable effect. The Huggins team has focused on referring patients who do not qualify for home health services but need some help.

During a recent call with the Huggins care coordination department, they shared the story of a patient who is unable to read or write, struggles with obesity and hypertension, and relied heavily on his wife to manage his care. She passed away this summer, and this patient quickly started to decompensate. One of the most significant barriers he encountered was not being able to read nutrition label so that he could make health selections that aligned with his dietary restrictions. The Huggins team connected him to a CHW who shopped with him, helping him select items that met his dietary requirements. During the trip, the CHW took pictures of the items he purchased and later used those photos to create a deck of flashcards that the client could take with him into the stores, matching the cards to the products to ensure that he selected healthy items. Now he shops for himself, and his chronic conditions are improving again. Huggins looks forward to more such success stories emerging from their partnership with the W2WC team.

Indian Stream Health Center (ISHC)

At the beginning of the reporting period, ISHC continued to deliver enhanced care coordination services to patients of their federally qualified health center. This included ongoing assessment of needs related to social determinants of health, the use of risk stratification to refer patients to care coordination services, and partnerships with social service organizations in the Colebrook community who could provide needed supports to ISHC patients. The organization was also heavily engaged in converting to a new health information system, and a lot of thought was put into the build of this platform so information that drives enhanced care coordination could be captured and communicated in a timely fashion in the future.

As the pandemic has progressed, ISHC has experienced significant staffing challenges while also struggling with the implementation of a new electronic medical record. One of these upgrades is the additional of several fields for Social Determinant of Health indicators, and they hope to utilize these new fields to serve an effort to work closer with behavioral health providers. ISHC also continues to utilize the event notifications from the Collective Medical Technologies network as a tool for their Care Management Nurses to gain visibility into patient visits to outside-of-region facilities. They report their visibility into patient visits to in-region partner hospitals like Upper Connecticut Valley Hospital was already in place through other means.

By July, the behavioral health department was down to a single LICSW and the organization began looking at alternate models for connecting their patients to these services. Leveraging connections to former employees that had relocated to other states, ISHC was able to successfully engage a psychologist and an LICSW who were able to provide telehealth services to the clinic. ISHC adapted two offices in their building to serve as receiving sites for patients who have poor internet access in their homes but can attend telehealth sessions at the clinic. As this model was implemented, ISHC noted that visit volumes have increased on a weekly basis, and the work culminated in securing telehealth

consultation services for primary care providers with a psychiatrist that provides medication management support for 5 hours each week.

Prior to the pandemic, the Care Management team had been working on a process that would allow their staff to go to the hospital to begin working with inpatients prior to discharge. The pandemic forced the team to put those plans on hold, but they intend to revisit them as they return to more normal operations as the pandemic resolves. The ISHC team also noted that they have identified 900 patients on their panel that are eligible for chronic care management (CCM) services but are not currently enrolled in the program due to time constraints of the staff. As the team continues to evolve their care management services program, they are working to develop a model that kicks off CCM services with a face-to-face visit and then continues through telemedicine modes. The team hopes that telemedicine can remain a valued way of contacting patients and providing follow-up services after the Governor's emergency orders expire.

Memorial Hospital (Memorial)

Staff at Memorial report that, when the public health emergency was announced in March, much of the staff effort at this partner organization shifted inward as the organization focused on readying their Critical Access Hospital to handle potential surge in COVID related cases. Ambulatory practices were closed, and staff were retasked to the COVID effort. Patients were discouraged from attending in-person visits unless absolutely necessary, and Memorial worked closely with their parent organization, MaineHealth, to stand up telehealth services for their patient population.

Telehealth was particularly successful with the behavioral health population, and providers have been able to continue meeting with up to 8 patients per day throughout the pandemic. Memorial's Integrated Medication Assisted Treatment (IMAT) program has continued to operate via telemedicine during this reporting period, but support groups continue to be suspended due to a lack of adequate physical space to accommodate group size and the need for some participants to have on-site childcare. Memorial has seen an increase in the number of people seeking emergency services for behavioral health needs, which they credit to the isolation experienced by people during the pandemic. The facility struggles with boarding behavioral health patients in the Emergency Department due to a lack of in-house services to work with them. Staff reports that, as a result of the economic impact of the COVID-related suspension of elective services earlier in the year, focus has been on reinvigorating services lines that better support the financial health of the organization first. The facility is performing COVID testing on more than 150 people per day and the full consumption of resources is focused on COVID response efforts.

Northern Human Services (NHS)

NHS continues to leverage the expansion of telehealth under executive orders implemented during the pandemic but notes a continued challenge in using this service delivery mode for patients with serious mental illness as it has for patients with less acute needs. This is in part, because it is more difficult for individuals to remain focused and engaged when speaking to their providers over the phone or through a video conference call. To mitigate this challenge, providers at NHS have continued to offer more frequent but shorter telehealth visits for this patient population. As COVID case counts rose across the region during this reporting period, NHS moved most appointments on both the mental health and developmental disabilities sides of their operations to telehealth modes, maintaining limited staffing in each of NHS' six office locations during the reporting period in order to provide care and case management services to individuals who cannot participate in telehealth services.

Whether virtual or in person, NHS staff continued to evaluate their clients for needs related to social determinants of health and connected them to the social service organizations best positioned to address those needs. Functional support workers have continued to engage clients with developmental disabilities throughout the pandemic. Many of these clients have physical conditions or diseases that have placed them at high-risk during the COVID-19 pandemic. As a result, these clients have been advised to stay at home as much as possible. Functional support workers continue to provide support to their clients by picking up groceries, prescriptions and running other errands. In the latter half of the reporting period, NHS worked closely with the North Country Public Health Network to secure testing supplies that allowed them to closely monitor clients and staff in their residential locations for COVID-19 infection.

Saco River Medical Group (SRMG)

SRMG reported that their care coordinator has continued to engage patients and receive referrals from the seven primary care providers working in the office. During the reporting period 18 new patients were enrolled in the enhanced care coordination program. The care coordinator has also taken responsibility for the transitional care management workflows for the practice and has assisted 80 patients in their transitions from inpatient or residential care back into community.

During the COVID pandemic, this primary care practice has remained open for business as usual, adding telehealth capacity for those patients who felt more comfortable meeting with their primary care provider in a virtual setting instead of coming to the office for an in-person visit. In an effort to ensure that infection prevention practices were followed, the clinic did ask patients to consider their cars as the waiting room for their visit rather than congregate inside the clinic building as they waited for their appointments. SRMG does note that their patients continued to report being fearful of coming to the clinic, and they have seen a significant decrease in volume for their walk-in clinic, particularly in the pediatric population.

Information regarding social determinants of health continues to be collected as part of the Core Comprehensive Standardized Assessment (CCSA) process, and during the reporting period they have built the CCSA into Athena, their new electronic medical record. SRMG reports that they continue to be enrolled in a number of incentive payment programs with commercial payers and are leveraging the data analysis available through those commercial programs to monitor their success at the management of chronic disease burden within their patient population.

Weeks Medical Center (WMC)

WMC continued to provide enhanced care coordination services throughout the reporting period, working together with fellow North Country Healthcare Partners Upper Connecticut Valley Hospital and Androscoggin Valley Hospital to ensure that COVID-19 testing was easily accessible to community members within their catchment area. No update was available from this partner for the current reporting period, largely due to the significant work underway at the facility to implement a new electronic medical record system and serve as one of the state's COVID testing centers. No additional updates have become available during the review period.

White Mountain Community Health Center (WMCHC)

WMCHC was positioned to stand up telehealth services more quickly than other partners in the region because they were already using telehealth technology as part of a partnership with Dartmouth Hitchcock Medical Center. During the reporting period, WMCHC has leveraged UpDox, a health information technology product originally purchased through the use of Region 7 IDN funding, to

distribute registration forms, questionnaires, and screening tools to patients electronically. This includes the Core Comprehensive Standardized Assessment, with patient responses directly populating the medical record for follow-up by staff. The enhanced care coordination program at WMCHC is continuing to use risk stratification to identify patients for whom interventions are needed and are also providing enhanced care coordination to all prenatal patients.

Providers at WMCHC remained in close contact with social workers and care coordinators through notes made in the medical record. WMCHC staff did express concern that not seeing patients in person prevented providers from adequately assessing risk for things like domestic violence and child abuse. As noted by other partners on this project, WMCHC is finding that staff spend significant amounts of time ensuring that families in quarantine have the food resources they need in order to remain in extended quarantine and are connected to social service supports to address the loss of income because so many of these individuals work seasonal jobs that do not offer vacation time or paid sick leave. Everybody that needs to quarantine is referred to social work or at least given the social worker and CHW as a resource for extra support because the practice recognizes that families won't comply with quarantine if they are at risk of going hungry. Social workers have also dedicated considerable time in the last half of the reporting period to helping families who need help with remote learning due to inadequate technology or internet access.

North Country Health Consortium (NCHC)

As the original program funding for the NCHC Ways 2 Wellness CONNECT (W2WC) program was ending at the end of June, NCHC drafted a proposal to provide Community Health Worker services to all Region 7 IDN partners, with the goal of supporting and strengthening the work of Region 7 IDN partners around enhanced care coordination services in Northern Grafton, Coös and Carrol Counties. The proposal also included expanding the ages of patients served to adults 18 and over with chronic disease, thus encouraging interventions to happen more upstream to improve overall outcomes. In addition, and in response to partner's interest, the proposal also included offering CHW Training to Region 7 IDN partner organizations; providing mentorship for CHWs in partner organizations; and technical assistance to organizations seeking to set up a CHW program. The Region 7 IDN Steering Committee approved the proposal, which set out to extend the program within the following parameters:

- A maximum of 8 partners will be provided the opportunities described in this proposal. Availability will be on a "first come, first serve" basis.
- The W2WC program will provide direct service to assist up to 50 patients during the timeframe of July 1, 2020 – June 30, 2021.
- All services are provided at no-cost to the partner or the patient.
- During COVID-19, patient services will be provided following the recommended protocols to protect both CHWs and patients.

In December, the W2WC provided an interim report on the progress of this one-year project. At the time of this interim report, the following work has been accomplished with funding:

- Direct Service: W2WC worked with adults across the spectrum of their chronic disease. CHW interventions in the preliminary stages of chronic disease will support provider's efforts to move upstream to prevent unmanaged chronic disease. CHWs provide patient education, behavior modification, medication adherence reinforcement and connection to resources to address social determinants of health that create the barriers to managing illness. Six Region 7 IDN partners have participated in the direct service component including: Weeks Medical Center,

Littleton Regional Hospital and Primary Care, Indian Stream Health Center, Huggins Hospital, Rowe/Cottage Hospital and Coos County Family Health Services. Total clients served during the time period of July 1, 2020 and December 9, 2020 is 52. The funding deliverable called for a total of 50 clients to be served during the funding period of July 1, 2020- June 30, 2021

- Workforce Development: Workforce development opportunities available to Region 7 IDN Partners with this current funding includes:
    - CHW Training to build care coordination workforce capacity. NCHC's CHW training is based on the textbook: "Foundations for Community Health Workers, 2nd Edition", developed for the CHW Training program at City College in San Francisco and customized for New Hampshire. The 80-hour training was provided virtually due to COVID-19, including Motivational Interviewing and home study. The training was developed to meet the needs of adult learners using visual, auditory, written word and experiential teaching techniques and follows the nationally accepted CHW core competencies. The first virtual CHW training was completed in November 2020, graduating 9 CHWs. A second CHW training is scheduled to begin in January 2021. Four Region 7 IDN partner organizations sent staff members to complete this training: White Horse, Family Resource Center, Service Link and NCHC/Friendship House.
    - Technical Assistance (TA) and Mentoring to support CHW program integration and development at partner organizations. Technical assistance is to be provided through proven program models and mentoring based on partner needs to increase the efficiency and effectiveness of the current workforce. Mentoring can be provided to care coordination or patient navigation staff to share problem-solving expertise, resource navigation guidance, and communication and navigation skills. No partners have requested this service at this time.

Ten Region 7 IDN partners have participated in the activities offered within this proposal, exceeding the funding deliverable that called for a maximum of eight engaged partners by June 30, 2021. Additionally, NCHC and the W2WC program have served as a technical advisor and provided leadership for the NH CHW Coalition. The Coalition has evolved into a formalized group of CHWs and Stakeholders that have a vision for integration of a CHW workforce in the state. The Coalition has focused efforts on analyzing certification processes and requirements nationally to inform efforts in New Hampshire. Certification is hoped to advance the formalization, integration, and sustainability of the CHW workforce across different disciplines.

The W2WC team notes that the current COVID-19 landscape has provided many new challenges. CHWs can help fill workforce gaps and afford needed relief to providers, allowing them to work at their licensure level and be responsive to the demands of COVID-19. During the reporting period, CHWs have worked hard to navigate the restrictions that the current epidemic places on how they can interact with both clients and referrers. Over the summer months when the COVID-19 numbers had decreased, CHWs were equipped with all needed PPE and provided training on safety procedures for making home visits. These visits put their creativity to the test as they worked to meet on porches, in yards and from a safe distance. Unfortunately, with the more recent rise in COVID-19 numbers, CHWs are currently restricted to working with clients through the phone and mail. Although this impedes the CHW's ability to see the client's living situation, and phone contact is not a replacement for in-person connections, the CHWs have made a huge effort to be that trusted voice on the other end of the phone and use their creative skills to find solutions. Currently the W2WC program is assembling small safety packages for

clients that include donated handmade masks, hand sanitizer and wipes as a reminder for all their clients to put safety first.

An additional barrier was the need for additional CHW capacity to meet the volume of client referrals for W2WC services. Through communication with the Region 7 IDN Steering Committee and submission of an expansion proposal, NCHC has received additional support to expand the CHW team and extend programming through December 2022. The team notes that being able to work with people sooner, both younger and sooner in the disease progression, provides a better opportunity to meet their goal of targeting a broader span and move upstream in the work to disrupt the development of chronic diseases. Overall, the clinical organizations with whom the W2WC team works continue to be invested in extraordinarily successful partnerships. Some organizations have not embraced the roll of CHWs, but the team continues to provide information to providers across the region and hopes to see sustained uptake of these services. With the addition of another CHW effective January 1, the W2WC hopes to expand their outreach to Region 7 IDN partners, and activity that had to be suspended due to size of client panels.

During the reporting period, the W2WC program continued to look for opportunities to work within their communities to meet the needs as presented. Staff note that this matters a lot around COVID, due to the impacts of isolation, lack of transportation, and clients not feeling safe going out. While CHWs can't meet clients face to face at this time, they continue to be incredibly supportive of dropping things off and then talking with clients on the phone about them. The W2WC team also works very closely with other community-based organizations across the region whose services and supports are proving invaluable to W2WC clients during the pandemic. The team is constantly shifting with the community need – a practice that they see as enhanced care coordination at its best.

Carroll County Coalition for Public Health (C3PH)

While not a direct provider of enhanced care coordination, C3PH's position in community as the home of the Carroll County Public Health Network makes it uniquely able to see the impact of a network like the Region 7 IDN. C3PH notes that the partners that work with CHWs – either embedded in their own organizations or through a contractual relationship - seem to be most successful in the Enhance Care Coordination arena. C3PH also reports that those organizations with integrated behavioral and physical health are better positioned to respond to mental health crises, which ultimately has ripple effects into the community as individuals are connected to care in a timely manner. As the pandemic has progressed, C3PH has been taking note of several key projects underway across the region to address what has been named as a developing second pandemic of mental health needs exacerbated the COVID-19. This includes suicide prevention work happening under the Garrett Lee Smith grant, which has C3PH, NCHC and NHS as three of the contracted participants in Region 7, as well as statewide work coming from NAMI NH focused on early identification of first episode psychosis and timely referral to care for young adults.

Project Targets

Use the format below to provide a list of all of the progress toward targets that the program has achieved. Targets should include.

- Number of individuals served (during reporting period and cumulative)
- All performance measures identified in the evaluation project plan.

When the inpatient readmission and Emergency Department visit measures were developed, they were based on information in Databooks provided by the State in 2016, which contained baseline data from 2015 claims. At the time that the Region 7 IDN Implementation Plan was written, these databooks represented the only baseline available for many data points, and IDNs had the impression that the databooks would be issued on some recurring basis during the demonstration period. This has not been the case and it does not appear, at this time, that any refresh of the databooks will provide an adequate measure of the efficacy of IDN interventions. As an alternative, the measures highlighted below have been adapted to align with comparable DSRIP performance measures for which data is refreshed more regularly.

Performance Measure Name	Target	Progress Toward Target				
		12/31/18	6/30/19	12/31/19	6/30/20	12/31/20
ECC - Reduced hospital inpatient readmissions for patients with BH indicators as evidenced by a decrease in annual 30-day hospital readmissions rate per 1,000 population. As noted above, this measure was originally established using 2015 baseline data made available in the 2016 release of the State's Databook 4. Since that data source has not been refreshed regularly, this row will now contain the data available for HOSP_INP.01: Readmission to Any Hospital for Any Cause by Adult Behavioral Health Population Within 30 Days.	20% decrease (from 9.1 in 2015 to 7.2 by 2020)	N/A – waiting to receive claims-based data	Target = 1.17; Result = 1.18	Target = 1.14; Result = 1.18	**N/A – Not measured in 2020**	**N/A – Not measured in 2020**
ECC - Reduced Number of ED visits for patients with BH indicators as evidenced by a decrease in annual emergency department visits for patients with behavioral health indicators rate per 1,000 population. As noted above, this measure was originally established using 2015 baseline data made available in the 2016 release of the State's Databook 2. Since that data source has not been refreshed regularly, this row will now contain the data available for HOSP_ED.01: Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population. Consistent with information provided to Region 7 IDN by the DHHS Office of Quality Assurance and Improvement, each subsequent column lists the DHHS established target and any available results for the corresponding reporting period.	20% decrease (from 1073 in 2015 to 858 by 2020) Baseline Rate = 8.50%	Target = 8.18%; Result = 6.10%	Target = 6.99%%; Result = 6.15%	Target = 5.80%; Result = **6.65%**	**N/A – Not measured in 2020**	**N/A – Not measured in 2020**
Sub-recipient proposals received which are related to Enhanced Care Coordination	5	10	10	10	10	10
Convene 1 Care Advocate Workgroup	1	1	1	1	1	1

Performance Measure Name	Target	Progress Toward Target				
		12/31/18	6/30/19	12/31/19	6/30/20	12/31/20
Regional care coordination trainings	3	2	2 IDN sponsored, as well as extensive ongoing training for regional care coordinators engaged in ACOs	3	3	3
Community Health Worker Trainings	3	2	2	3	3	5
CHW cross trained as Peer Recovery Coaches	8	7	9	11	10	9
Region 7 IDN agencies with embedded Community Health Workers	5	5	7	7	7	7
Agencies working on Enhanced Care Coordination as defined by DSRIP metrics	3	11	12	11	11	11
Trained Care Advocates	15	11	21	18	17	17
Partner organizations that have agreements in place for referral process	4	7	7	8	8	8
E5 - Individuals served vs. projected. * As a result of diminished staff resources during the COVID pandemic, several partners reported being unable to contribute data to this metric by the filing of this report. Attempts will be made to update this data point during the writeback process.	45	127	1027	1897	1575	1789*
E5 - Staff recruited and trained vs. projected	23	18	28	29	29	27

Budget

Provide a narrative and a brief project budget outlining actual expenditures and projected costs to support the community project which must include financial reporting. In your narrative please also speak to any variances from your proposed cost to your actual spending.

Budget Period:	01/01/2017-12/31/2017	01/01/2018-12/31/2018	1/1/2019 - 6/30/2019	7/1/2019 - 12/31/2019	1/1/2019 - 12/31/2019	1/1/2020 - 6/30/2020	7/1/2020 - 12/31/2020	01/01/2020-12/31/2020	01/01/2021-12/31/2021
Care Coordination	CY 2017 Actuals	CY 2018 January to December ACTUAL	CY 2019 January to June ACTUAL	CY 2019 July to December ACTUAL	CY 2019 January to December ACTUAL	CY 2020 Jan to June ACTUAL	CY 2020 July to Dec ACTUAL	CY 2020 ACTUAL	CY 2021 Projected
1. Total Salary/Wages									
2. Employee Benefits									
3. Consultants									
5. Supplies:									
Educational									
Office	968	$147	$116	$95	$211	$73	$20	$94	$38
6. Travel		$368	$202	$202	$405	$44	$94	$137	$94
7. Occupancy									
8. Current Expenses									
Telephone									
Postage									
Subscriptions									
Audit and Legal									
Insurance									
Board Expenses									
9. Software		$443	$238	$386	$624	$134	$113	$247	$95
10. Marketing/Communications	1,086	$2,369	$179	$192	$371	$17	$1	$19	$9
11. Staff Education and Training		$522	$272	$272	$544	$188	$66	$254	$66
12. Subcontracts/Agreements									
13. Other (specific details mandatory):									
Current Expenses: Administrative Lead Organizational Support	1,634	$2,236	$294	$275	$569	$158	$39	$198	$84
Support Payments to Partners	65,766	$103,325	$26,708	$41,407	$68,115	$9,047	$17,189	$26,236	$97,657
TOTAL	91,231	$140,409	$50,737	$61,798	$112,535	$24,629	$29,563	$54,194	$105,767

At the beginning of the demonstration, Region 7 opted to take the approach of budgeting based on how incentive payments are earned. This approach has been used for staffing as well as partner requests for funds and was adopted because partner proposals and staff time often touch multiple DSRIP projects concurrently. Expenses have therefore been allocated as a flat percentage across project areas, with the region setting out initially to roughly budget the funding across projects in parallel to the proportions in which the incentive payments were earned.

As funding uncertainties mounted in 2018 and 2019, the region maintained the original allocation rather than making the shift in the weighting from the state-wide projects to the core competency project. This has resulted in allocations of approximately 42% of funding to state projects, 36% to the core competency project and 22% to community projects for the life of the DSRIP. Proposed expenses for the remainder of the demonstration include anticipated costs for infrastructure staffing, subscription to the Collective Medical Network and distribution of remaining earned incentive payments to partner organizations in support of their ongoing work to meet the goals of the DSRIP. Variances experienced to date include:

- Reductions in incentive payments available following decreased county contributions for years 3 and 4.
- Failure of the region to meet 100% of incentive payment targets for both process and performance measures.
- The restructuring of infrastructure staffing in line with decreased funding earned by the region, the rationale being that if there was less money available for partner organizations, the infrastructure team should be similarly reduced.

Project APM: DSRIP Alternative Payment Model (APM) Implementation Planning

As a part of the DSRIP demonstration, the state has committed to value-based health services reimbursements. The DSRIP APM Roadmap articulates the process by which the state will work with the IDNs, Medicaid Managed Care Organizations (MCO), and other Medicaid services stakeholders to develop a statewide APM workgroup for the completion of the DSRIP APM Implementation Plan. The goal of the DSRIP APM Implementation Plan is to achieve 50% Medicaid provider payments in an APM by 12/31/2020.

IDNs will be evaluated on their engagement with the state and managed care plans in support of the APM goals consistent with Special Terms and Conditions (STC) 24, Project Milestones; STC 33 MCO and Medicaid Service Delivery Contracting Plan; and STC Attachment C: DSRIP Planning Protocol IV Project Stages, Milestones, and Metrics.

APM Narrative

Provide a brief narrative which speaks to the following:

- Describe how the IDN is aligning performance metrics to the MCO APMs.
- Identify partners who are currently participating in or in the planning process for MCO APMs.

APM Narrative

As in prior reporting periods, the Region 7 IDN team has queried partner agencies working on the core competency integrated healthcare project to ascertain their readiness to enter into Alternative Payment Model (APM) contracts with payer sources. Most partners have reported that they currently hold payer contracts which include some form of incentive payment program that uses HEDIS measures to evaluate the quality of preventative care and chronic disease management for covered beneficiaries. Several partners have also previously participated in at least one round of a Medicare Shared Savings Program Accountable Care Organization demonstrations, with several North Country hospital partners currently enrolled in a down-side risk ACO.

Partners generally report that they feel prepared to deliver clinical care that is consistent with the standards of care upon which most APM quality metrics are based and are therefore clinically prepared to enter into APM contracts. As previously reported, partners continue to be reluctant to enter into down-side risk arrangements at this time because they have not yet established the infrastructure necessary to proactively manage data that will allow them to produce and act upon reliable care opportunity reports, adequately code claims to ensure that Hierarchical Condition Category stratification is accurate for beneficiaries and validate performance metric data as required by most APM contracts. Several partners have also expressed concern that quality metrics are still under development, so the targets continue to move and therefore leave rural providers in a continual loop of spending money to implement processes aimed at maximizing shared savings, only to have the goal posts moved to the next unattainable position the following year.